

<i>SERFF Tracking Number:</i>	<i>JEPT-126218170</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Lincoln National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42849</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Dental</i>		
<i>Project Name/Number:</i>	<i>2009 Dental Rewrite/</i>		

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Group Dental

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: JEPT-126218170

SERFF Status: Closed

Co Tr Num:

Co Status:

Authors: Matt Rotundo, Debbie
Turek, Bonnie White, Benjamin
Davis

Date Submitted: 07/07/2009

State: ArkansasLH

State Tr Num: 42849

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 07/10/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2009 Dental Rewrite

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/10/2009

Deemer Date:

Filing Description:

July 7, 2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 03/09/2009

Domicile Status Comments: The Lincoln
Financial Group is domiciled in Indiana.

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 07/10/2009

Corresponding Filing Tracking Number:

ARKANSAS INSURANCE DEPARTMENT

1200 WEST THIRD STREET

LITTLE ROCK, AR 72201-1904

SERFF Tracking Number: *JEPT-126218170* *State:* *Arkansas*
Filing Company: *The Lincoln National Life Insurance Company* *State Tracking Number:* *42849*
Company Tracking Number:
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Group Dental*
Project Name/Number: *2009 Dental Rewrite/*

NAIC No.: 0020-65676

FEIN No.: 35-0472300

Re: Group Dental Forms

Forms: GL11-3-SB 07 et al (See attached list)

Enclosed for filing with your Department are copies of the captioned forms. We are requesting that these be approved for general use with any of our previously approved Group Policy series GL11 and Group Certificate Series GL12 forms.

The enclosed forms are new and will not replace any previously filed forms. The forms incorporate changes we have made in the administration of our Dental product.

The forms have been filed with and approved by Indiana, our domiciliary state, on multiple dates. Indiana's most recent approval was on March 9, 2009.

The Appendix of Variability and a Readability Certification are attached. Your review and notice of approval will be greatly appreciated. If you have questions, please feel free to contact me.

Sincerely,

Benjamin A. Davis, Esq.

Compliance Analyst

Lincoln Financial Group

Voice: (800) 423-2765 ext. 7495

Fax: (402) 501-9308

E-Mail: benjamin.davis@lfg.com

SERFF Tracking Number: JEPT-126218170 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: 2009 Dental Rewrite/

Company and Contact

Filing Contact Information

Ben Davis, Compliance Specialist Benjamin.Davis@lfg.com
 8807 Indian Hills Drive (402) 361-7495 [Phone]
 Omaha, NE 68114 (402) 361-2568[FAX]

Filing Company Information

The Lincoln National Life Insurance Company	CoCode: 65676	State of Domicile: Indiana
350 Church Street	Group Code: 20	Company Type: Group
Hartford, CT 06103	Group Name:	State ID Number:
(800) 423-2765 ext. [Phone]	FEIN Number: 35-0472300	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00 per submission.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	\$50.00	07/07/2009	29029084

SERFF Tracking Number: *JEPT-126218170* *State:* *Arkansas*
Filing Company: *The Lincoln National Life Insurance Company* *State Tracking Number:* *42849*
Company Tracking Number:
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Group Dental*
Project Name/Number: *2009 Dental Rewrite/*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/10/2009	07/10/2009

<i>SERFF Tracking Number:</i>	<i>JEPT-126218170</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Lincoln National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42849</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Dental</i>		
<i>Project Name/Number:</i>	<i>2009 Dental Rewrite/</i>		

Disposition

Disposition Date: 07/10/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: JEPT-126218170 State: Arkansas

Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849

Company Tracking Number:

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: Group Dental

Project Name/Number: 2009 Dental Rewrite/

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes
Form	Eligibility and Effective Dates for Employee Dental Coverage	Approved-Closed	Yes
Form	Termination of Employee Dental Coverage	Approved-Closed	Yes
Form	Eligibility/Effective Dates for Dependent Dental Coverage	Approved-Closed	Yes
Form	Termination of Dependent Dental Coverage	Approved-Closed	Yes
Form	Premiums and Premium Rates	Approved-Closed	Yes
Form	Policy Termination	Approved-Closed	Yes
Form	Dental Expense Benefits	Approved-Closed	Yes
Form	Alternative Procedures	Approved-Closed	Yes
Form	Dental Expense Benefits (Orthodontics)	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Coordination of Dental Expense Benefits	Approved-Closed	Yes
Form	Dental Coverage Continuation	Approved-Closed	Yes
Form	Continuity of Coverage	Approved-Closed	Yes
Form	Prior Plan Credit	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 1)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 2)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 3)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 4)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 1) (Scheduled Benefit Plan)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type	Approved-Closed	Yes

SERFF Tracking Number: JEPT-126218170 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: 2009 Dental Rewrite/

2) (Scheduled Benefit Plan)

Form	List of Covered Dental Procedures (Type 3) (Scheduled Benefit Plan)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 4) (Scheduled Benefit Plan)	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes
Form	Eligibility and Effective Dates for Employee Dental Coverage	Approved-Closed	Yes
Form	Termination of Employee Dental Coverage	Approved-Closed	Yes
Form	Eligibility/Effective Dates for Dependent Dental Coverage	Approved-Closed	Yes
Form	Termination of Dependent Dental Coverage	Approved-Closed	Yes
Form	Dental Expense Benefits	Approved-Closed	Yes
Form	Alternative Procedures	Approved-Closed	Yes
Form	Dental Expense Benefits (Orthodontics)	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Coordination of Dental Expense Benefits	Approved-Closed	Yes
Form	Dental Coverage Continuation	Approved-Closed	Yes
Form	Continuity of Coverage	Approved-Closed	Yes
Form	Prior Plan Credit	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 1)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 2)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 3)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 4)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 1) (Scheduled Benefit Plan)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type 2) (Scheduled Benefit Plan)	Approved-Closed	Yes
Form	List of Covered Dental Procedures (Type	Approved-Closed	Yes

SERFF Tracking Number: JEPT-126218170 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: 2009 Dental Rewrite/

3) (Scheduled Benefit Plan)

Form

List of Covered Dental Procedures (Type Approved-Closed Yes
4) (Scheduled Benefit Plan)

SERFF Tracking Number: JEPT-126218170 State: Arkansas

Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849

Company Tracking Number:

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: Group Dental

Project Name/Number: 2009 Dental Rewrite/

Form Schedule

Lead Form Number: GL11-3-SB 07

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GL11-3-SB 07	Policy/Cont	Schedule of Benefits ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		53	3SB07 Rev 0109.pdf
Approved-Closed	GL11-4-DF 09	Policy/Cont	Definitions ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		57	4DF09.pdf
Approved-Closed	GL11-6-ELE 07	Policy/Cont	Eligibiilty and ract/Fratern al Employee Dental Certificate: Coverage Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52	6ELE07.pdf
Approved-Closed	GL11-7-TE 07	Policy/Cont	Termination of ract/Fratern al Employee Dental Coverage Certificate: Amendmen	Initial		51	7TE07Rev 0109.pdf

SERFF Tracking Number: JEPT-126218170 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: 2009 Dental Rewrite/

t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-8- Policy/Cont Eligibility/Effective Initial 62 8ELD09AR.p
Closed ELD 09 AR ract/Fratern Dates for Dependent df
al Dental Coverage

Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-9-TD Policy/Cont Termination of Initial 55 9TD07Rev
Closed 07 ract/Fratern Dependent Dental
al Coverage

Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-10- Policy/Cont Premiums and Initial 60 10PR09.pdf
Closed PR 09 ract/Fratern Premium Rates
al

Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-11- Policy/Cont Policy Termination Initial 64 11PT08.pdf
Closed PT 08 ract/Fratern
al

Certificate:
Amendmen
t, Insert
Page,

SERFF Tracking Number: JEPT-126218170 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: 2009 Dental Rewrite/

Endorseme
nt or Rider

Approved- GL11-12- Policy/Cont Dental Expense Initial 51 12DB07.pdf
Closed DB 07 ract/Fratern Benefits

al
Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-13- Policy/Cont Alternative Initial 50 13AP07.pdf
Closed AP 07 ract/Fratern Procedures

al
Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-14- Policy/Cont Dental Expense Initial 51 14DBO07.pdf
Closed DBO 07 ract/Fratern Benefits

al (Orthodontics)
Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-16- Policy/Cont Limitations and Initial 50 16EX09.pdf
Closed EX 09 ract/Fratern Exclusions

al
Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

SERFF Tracking Number:	JEPT-126218170	State:	Arkansas
Filing Company:	The Lincoln National Life Insurance Company	State Tracking Number:	42849
Company Tracking Number:			
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	Group Dental		
Project Name/Number:	2009 Dental Rewrite/		

Approved- Closed	GL11-17- COB 07	Policy/Cont Coordination of ract/Fratern Dental Expense al Benefits Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	54	17COB07.pdf
Approved- Closed	GL11-20 07-COBRA	Policy/Cont Dental Coverage ract/Fratern Continuation al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	54	20 07 COBRA.pdf
Approved- Closed	GL11- CONT 09	Policy/Cont Continuity of ract/Fratern Coverage al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	62	CONT09.pdf
Approved- Closed	GL11-PIC 07	Policy/Cont Prior Plan Credit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	PIC07AR.pdf
Approved- Closed	GL11-DP.1 07	Policy/Cont List of Covered ract/Fratern Dental Procedures	Initial	0	DP107 Rev 0109.pdf

SERFF Tracking Number: JEPT-126218170 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: 2009 Dental Rewrite/

al (Type 1)

Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-DP.2 Policy/Cont List of Covered Initial 0 DP207 Rev
Closed 07 ract/Fratern Dental Procedures 0109.pdf

al (Type 2)

Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-DP.3 Policy/Cont List of Covered Initial 0 DP307 Rev
Closed 07 ract/Fratern Dental Procedures 0109.pdf

al (Type 3)

Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11-DP.4 Policy/Cont List of Covered Initial 0 DP407 Rev
Closed 07 ract/Fratern Dental Procedures 0109.pdf

al (Type 4)

Certificate:
Amendmen
t, Insert
Page,
Endorseme
nt or Rider

Approved- GL11- Policy/Cont List of Covered Initial 0 DPSB107.pdf
Closed DPSB.1 07 ract/Fratern Dental Procedures

al (Type 1) (Scheduled
Certificate: Benefit Plan)

SERFF Tracking Number: JEPT-126218170 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: 2009 Dental Rewrite/

Amendmen
 t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- Closed	GL11- DPSB.2 07	Policy/Cont List of Covered ract/Fratern Dental Procedures al (Type 2) (Scheduled Certificate: Benefit Plan) Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0	DPSB207.pdf
Approved- Closed	GL11- DPSB.3 07	Policy/Cont List of Covered ract/Fratern Dental Procedures al (Type 3) (Scheduled Certificate: Benefit Plan) Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0	DPSB307 Rev 0109.pdf
Approved- Closed	GL11- DPSB.4 07	Policy/Cont List of Covered ract/Fratern Dental Procedures al (Type 4) (Scheduled Certificate: Benefit Plan) Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0	DPSB407.pdf
Approved- Closed	GL12-3-SB 07	Certificate Schedule of Benefits Amendmen t, Insert Page, Endorseme nt or Rider	Initial	51	3SB07 Rev 0109.pdf

SERFF Tracking Number: JEPT-126218170 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: 2009 Dental Rewrite/

Approved- Closed	GL12-4-DF 09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Definitions	Initial	58	4DF09.pdf
Approved- Closed	GL12-6- ELE 07	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Eligibility and Effective Dates for Employee Dental Coverage	Initial	51	6ELE07.pdf
Approved- Closed	GL12-7-TE 07	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Termination of Employee Dental Coverage	Initial	50	7TE07Rev 0109.pdf
Approved- Closed	GL12-8- ELD 09 AR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Eligibility/Effective Dates for Dependent Dental Coverage	Initial	61	8ELD09AR.p df
Approved- Closed	GL12-9-TD 07	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Termination of Dependent Dental Coverage	Initial	52	9TD07Rev 0109.pdf
Approved- Closed	GL12-12- DB 07	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Dental Expense Benefits	Initial	52	12DB07.pdf
Approved- Closed	GL12-13- AP 07	Certificate Amendmen	Alternative Procedures	Initial	50	13AP07.pdf

SERFF Tracking Number: JEPT-126218170 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: 2009 Dental Rewrite/

t, Insert
Page,
Endorseme
nt or Rider

Approved- GL12-14- Certificate Dental Expense Initial 51 14DBO07.pdf
Closed DBO 07 Amendmen Benefits

t, Insert (Orthodontics)
Page,
Endorseme
nt or Rider

Approved- GL12-16- Certificate Limitations and Initial 51 16EX09.pdf
Closed EX 09 Amendmen Exclusions

t, Insert
Page,
Endorseme
nt or Rider

Approved- GL12-17- Certificate Coordination of Initial 53 17COB07.pdf
Closed COB 07 Amendmen Dental Expense

t, Insert Benefits
Page,
Endorseme
nt or Rider

Approved- GL12-20 Certificate Dental Coverage Initial 54 20 07
Closed 07-COBRA Amendmen Continuation COBRA.pdf

t, Insert
Page,
Endorseme
nt or Rider

Approved- GL12- Certificate Continuity of Initial 63 CONT09.pdf
Closed CONT 09 Amendmen Coverage

t, Insert
Page,
Endorseme
nt or Rider

Approved- GL12-PIC Certificate Prior Plan Credit Initial 51 PIC07.pdf
Closed 07 Amendmen

t, Insert
Page,

SERFF Tracking Number: JEPT-126218170 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: 2009 Dental Rewrite/

Endorseme
nt or Rider

Approved- Closed	GL12-DP.1 07	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	List of Covered Dental Procedures (Type 1)	Initial	0	DP107 Rev 0109.pdf
Approved- Closed	GL12-DP.2 07	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	List of Covered Dental Procedures (Type 2)	Initial	0	DP207 Rev 0109.pdf
Approved- Closed	GL12-DP.3 07	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	List of Covered Dental Procedures (Type 3)	Initial	0	DP307 Rev 0109.pdf
Approved- Closed	GL12-DP.4 07	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	List of Covered Dental Procedures (Type 4)	Initial	0	DP407 Rev 0109.pdf
Approved- Closed	GL12- DPSB.1	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	List of Covered Dental Procedures (Type 1) (Scheduled Benefit Plan)	Initial	0	DPSB107.pdf
Approved- Closed	GL12- DPSB.2	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	List of Covered Dental Procedures (Type 2) (Scheduled Benefit Plan)	Initial	0	DPSB207.pdf

SERFF Tracking Number: JEPT-126218170 State: Arkansas

Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849

Company Tracking Number:

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: Group Dental

Project Name/Number: 2009 Dental Rewrite/

Approved- GL12- Certificate List of Covered Initial	0	DPSB307
Closed DPSB.3 07 Amendmen Dental Procedures		Rev 0109.pdf
t, Insert (Type 3) (Scheduled		
Page, Benefit Plan)		
Endorseme		
nt or Rider		
Approved- GL12- Certificate List of Covered Initial	0	DPSB407.pdf
Closed DPSB.4 07 Amendmen Dental Procedures		
t, Insert (Type 4) (Scheduled		
Page, Benefit Plan)		
Endorseme		
nt or Rider		

SCHEDULE OF BENEFITS

DENTAL PREFERRED PROVIDER ORGANIZATION (PPO).

This plan is designed to provide high quality dental care while managing the cost of the care. To do this, the Policy encourages a Covered Person to seek dental care from Dentists who have signed a contract with the dental network being offered by the Policy. These Dentists are called Participating Dentists.

Use of a Participating Dentist is voluntary. The Covered Person may receive treatment from any Dentist he or she chooses. And he or she is free to change Dentists at any time. But, the Covered Employee's out-of-pocket expenses for covered services are usually lower when the services are provided by a Participating Dentist.

A Directory of Participating Dentists is available from the Group Policyholder. Information about Participating Dentists may also be obtained by:

- (1) accessing the Company's web site at **www.lincolfinancial.com**; or
- (2) calling the Company's Client Services Department (800) 423 - 2765.

This information is included on the ID card provided to each Covered Employee. When the Covered Employee enrolls Eligible Dependents, two ID cards will be provided.

When using a Participating Dentist, the Covered Person must present the ID Card. Most Participating Dentists prepare the necessary claim forms, and submit them to the Company for the Covered Person. Benefits are based on the terms of the Policy.

CLASSIFICATION

Plan 1 - Employees located in a PPO service area

Class 1 All Full-Time Employees located in a PPO service area in ZIP Code(s) 123, 456

Plan 2 - Employees located outside a PPO service area

Class 2 All Full-Time Employees located outside a PPO service area in ZIP Code(s) 123, 456

ELIGIBILITY WAITING PERIOD (For date coverage begins, refer to "Effective Date" section)

For Plan 1: 30 days of continuous Active Work

For Plan 2: 30 days of continuous Active Work

SCHEDULE OF BENEFITS (Continued)

Plan 1 - Employees located in a PPO service area

BENEFITS FOR CLASS 1

Eligible Class: All Full-Time Employees located in a PPO Service Area in ZIP Code(s) 123, 456

Contributions: Covered Employees are required to contribute to the cost for Employee Dental Coverage. Covered Employees are required to contribute to the cost for Dependent Dental Coverage.

Benefit Waiting Period:

Type 2 Procedures:	<u>3 Months</u>
Type 3 Procedures:	<u>6 Months</u>
Type 4 Procedures:	<u>24 Months</u>

The Benefit Waiting Period(s) shown for Type 2, 3, and 4 Services will not apply to persons who become covered on the Policy issue date; but only if they were covered under the Group Policyholder's prior group dental plan on the day before the Policy issue date.

Prior Plan Credits: Terms of the Prior Plan Credit provision apply for persons enrolled on the issue date of this Policy. Refer to the Prior Plan Credit provision in this Policy.

Continuity of Coverage. Terms of the Continuity of Coverage provision apply to persons who were enrolled in another employer's group dental plan within 31 days before Dental Expense Benefits under this Policy take effect. See the Continuity of Coverage provision of this Policy.

Late Entrant Limitation (when applicable):

Type 2 Procedures:	<u>12 Months</u>
Type 3 Procedures:	<u>12 Months</u>
Type 4 Procedures:	<u>12 Months</u>

SCHEDULE OF BENEFITS (Continued)

Plan 1 - Employees located in a PPO Service Area in ZIP Code(s) 123, 456

BENEFITS FOR CLASS 1, continued

DENTAL BENEFITS

	PPO PLAN In-Network Services	PPO PLAN Out-of-Network Services
CALENDAR YEAR DEDUCTIBLE for these Procedure Types (combined)	Types 1 & 2	Types 1, 2 & 3
INDIVIDUAL	\$25	\$25
FAMILY	\$75	\$75
PERCENT PAYABLE		
Type 1 - Diagnostic & Preventive Services	100 %	80 %
Type 2 - Basic Services	80 %	60 %
Type 3 - Major Services	50 %	40 %
Type 4 - Orthodontic Services	50 %	50 %
Type 1, 2, and 3 Benefits Based On	Negotiated Fees	70 th Percentile of Usual & Customary Allowance
CALENDAR YEAR MAXIMUM for these Procedure Types (combined)	\$1,500 Types 1, 2 & 3	\$1,000 Types 1, 2 & 3
LIFETIME MAXIMUM for Type 4 Procedures – Orthodontics	\$1,500	\$1,000

On the CLAIMS PROCEDURES page, the provision captioned "TO WHOM PAYABLE" is amended to read as follows.

TO WHOM PAYABLE. Dental Expense Benefits generally will be paid to the Covered Employee; unless the Covered Employee has assigned such benefits to the Dentist, or an overpayment has been made. However, if services are provided by a Participating Dentist, benefits are automatically assigned to that Dentist, unless the bill has been paid.

SCHEDULE OF BENEFITS (Continued)

Plan 2 - Employees located outside a PPO service area in ZIP Code(s) 123, 456

BENEFITS FOR CLASS 2

Eligible Class: All Full-Time Employees located outside a PPO service area in ZIP Codes 123, 456

Contributions: Covered Employees are not required to contribute to the cost for Employee Dental Coverage. Covered Employees are required to contribute to the cost for Dependent Dental Coverage.

Benefit Waiting Period:

Type 2 Procedures:	<u>3 Months</u>
Type 3 Procedures:	<u>6 Months</u>
Type 4 Procedures:	<u>24 Months</u>

The Benefit Waiting Period(s) shown for Type 2, 3, and 4 Services will not apply to persons who become covered on the Policy issue date; but only if they were covered under the Group Policyholder's prior group dental plan on the day before this Policy's issue date.

Prior Plan Credits: Terms of the Prior Plan Credit provision apply for persons covered on the issue date of this Policy. Refer to the Prior Plan Credit provision in this Policy.

Continuity of Coverage. Terms of the Continuity of Coverage provision apply to persons who were enrolled in another employer's group dental plan within 31 days before Dental Expense Benefits under this Policy take effect. See the Continuity of Coverage provision of this Policy.

Late Entrant Limitation (when applicable):

Type 2 Procedures:	<u>12 Months</u>
Type 3 Procedures:	<u>12 Months</u>
Type 4 Procedures:	<u>12 Months</u>

DENTAL BENEFITS

CALENDAR YEAR DEDUCTIBLE

for Type 2 and 3 Procedures (combined)

INDIVIDUAL	\$25
FAMILY	\$75

PERCENT PAYABLE

Type 1 - Diagnostic & Preventive Services	100%
Type 2 - Basic Services	80%
Type 3 - Major Services	50%
Type 4 - Orthodontic Services	50%

Type 1, 2, and 3 Benefits Based On

85th Percentile of Usual &
Customary Allowance

CALENDAR YEAR MAXIMUM

for Type 1, 2, and 3 Procedures (combined)

\$1,000

LIFETIME MAXIMUM

for Type 4 Procedures - Orthodontics

\$1,000

DEFINITIONS

ACTIVE WORK or ACTIVELY AT WORK means an Employee's full-time performance of all customary duties of his or her occupation at:

- (1) the Group Policyholder's place of business; or
- (2) any other business location designated by the Group Policyholder.

Unless disabled on the prior workday or on the day of absence, an Employee will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday;
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis; or
- (4) a Military Leave or an approved Family or Medical Leave that is not due to the Employee's own health condition.

ANNUAL ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible Employees to purchase or make changes in their Employee or Dependent Dental Coverage.

Participation in an Annual Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period or Benefit Waiting Periods; and Late Entrant Limitations will apply.

APPROPRIATE TREATMENT (includes **APPROPRIATE**) means the range of services and supplies by which a dental condition may be treated, which falls within the accepted standards of dentistry. Appropriate Treatment may vary in techniques, materials utilized and technical complexity, as well as cost.

BENEFIT WAITING PERIOD means the period of time a Covered Person must be covered for Dental Expense Benefits -- or for a specific type of Dental Expense Benefits -- under this Policy before that type of service becomes eligible for coverage.

CHANGE IN FAMILY STATUS means a marriage, divorce, birth, death or change of employment or eligibility status or other event which qualifies under the requirements of Section 125 of the Internal Revenue Code of 1986, as amended. Change in Family Status also means the involuntary loss of comparable coverage under a spouse's employee benefit plan.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

COVERAGE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
- (2) ending at 12:00 midnight on the last day of the same calendar month;

at the Group Policyholder's primary place of business.

COVERED EMPLOYEE means an eligible Employee for whom the coverage provided by this Policy is in effect.

DEFINITIONS **(continued)**

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy. Covered Expenses:

- (1) for a Participating Dentist, do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the fee allowed by the Dentist's contract with the dental network;whichever is less; or
- (2) for a Non-Participating Dentist's charges, do not exceed[:
 - (a)] for Type 1, 2, or 3 procedures, this Policy's Usual and Customary allowances[; and
 - (b) for Type 4 procedures, the maximum Covered Expense, as determined by the Company].

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by this Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of this Policy.

COVERED PERSON means an eligible Employee or an eligible Dependent for whom the coverage provided by this Policy is in effect.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the Group Policyholder's place of business; when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

DEPENDENT: See the Eligibility for Dependent Dental Coverage section of this Policy.

DEPENDENT DENTAL COVERAGE means the coverage provided by this Policy for eligible Dependents.

ELIGIBILITY WAITING PERIOD means the continuous period of time that an Employee must be employed in an eligible class with the Group Policyholder, before he or she becomes eligible to enroll for coverage under this Policy.

This Eligibility Waiting Period may be waived for an Employee who qualifies for reinstatement of his or her coverage, as provided in this Policy.

EMPLOYEE means a Full-Time Employee or Regular Part-Time Employee of the Group Policyholder.

DEFINITIONS **(continued)**

EMPLOYEE DENTAL COVERAGE means the coverage provided by this Policy for eligible Employees.

EXPENSES INCURRED (includes **INCURRED**). An expense is Incurred at the time a service is rendered or a supply is furnished, except that an expense is considered Incurred:

- (1) for an appliance (or change to an appliance), at the time the impression is made;
- (2) for a crown or bridge, at the time the tooth or teeth are prepared; and
- (3) for root canal therapy, at the time the pulp chamber is opened;

provided the service is completed within 90 days from the date it is begun.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:

- (1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
- (2) is taken in accord with the Group Policyholder's leave policy and the law which applies; and
- (3) does not exceed the period approved by the Group Policyholder and required by that law.

The leave period, may:

- (1) consist of consecutive or intermittent work days; or
- (2) be granted on a part-time equivalency basis.

If an Employee is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If an Employee is on an FMLA leave due to his or her own health condition on the date Policy coverage takes effect, he or she is not considered Actively at Work.

FULL-TIME EMPLOYEE means an employee of the Group Policyholder:

- (1) whose employment with the Group Policyholder is the employee's principal occupation;
- (2) who is regularly scheduled to work at such occupation at least 30 hours each week;
- (3) who is not a temporary or seasonal employee;
- (4) who is a member of an employee class which is eligible for coverage under this Policy; and
- (5) who is a citizen of the United States or who legally works in the United States.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of this Policy. [It can also mean the Participating Employer, if applicable.]

INJURY means damage to a Covered Person's mouth, teeth, appliance, or dental prosthesis due to an accident that occurs while he or she is covered by this Policy. Damage resulting from chewing or biting food or other objects is not considered to be an Injury.

LATE ENTRANT means an eligible Employee who makes written application:

- (1) more than 31 days after the Employee first becomes eligible for Employee Dental Coverage;
- (2) after Employee Dental Coverage has been cancelled; or
- (3) after Employee Dental Coverage has been terminated due to failure to pay premiums when due.

DEFINITIONS (continued)

LATE ENTRANT also means an eligible Dependent for whom written application is made:

- (1) more than 31 days after he or she first qualifies for Dependent Dental Coverage;
- (2) after the Covered Employee has requested to terminate Dependent Dental Coverage; or
- (3) after Dependent Dental Coverage has been terminated due to failure to pay premiums when due.

Exception for involuntary loss of coverage under another group dental plan. A person will not be considered a Late Entrant if, due to the existence of coverage under an employer's group dental plan, the Employee and/or any Dependents did not enroll within 31 days of becoming eligible for coverage under this Policy; and coverage under the other plan ends for one of the following reasons:

- (1) termination of the other plan by the sponsoring employer;
- (2) loss of the Employee's eligibility in the other plan due to his or her termination of employment or a change in his or her employment classification;
- (3) loss of a spouse's eligibility under the other plan due to his or her termination of employment or a change in his or her employment classification; or
- (4) loss of the Employee's or a Dependent's eligibility under the other plan due to a divorce or the death of the spouse.

This exception will not apply if:

- (1) the loss of coverage under the other dental plan is voluntary (for example, voluntary termination of coverage based on premium contribution levels or the extent of benefits provided); or
- (2) a person enrolls for coverage under this Policy more than 31 days after becoming eligible following the loss of coverage continued under COBRA.

In order to qualify for this exception, each person applying for coverage under the Group Policyholder's dental plan must:

- (1) provide proof of coverage under the spouse's prior dental plan; and
- (2) enroll for coverage and pay premiums for the Group Policyholder's plan within 31 days following loss of coverage under the other dental plan.

LATE ENTRANT LIMITATION PERIOD means the period of time a Late Entrant must be covered for a specific type of Dental Expense Benefits under this Policy before that type of service becomes eligible for coverage.

MILITARY LEAVE means a leave of absence that:

- (1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
- (2) is taken in accord with the Group Policyholder's leave policy and the federal USERRA law; and
- (3) does not exceed the period required by that law.

DEFINITIONS (continued)

NECESSARY DENTAL PROCEDURE (includes **NECESSARY** and **DENTAL NECESSITY**) means a procedure, service or supply which the Company, or a qualified party selected by the Company, determines is:

- (1) required by, and Adequate and Appropriate for the diagnosis or treatment of a dental disease, condition or injury;
- (2) Appropriate and consistent with the symptoms and findings, or with the diagnosis and treatment of the Covered Person's dental disease, condition or injury;
- (3) provided in accord with generally accepted professional standards for dental practice, consistent with current scientific evidence and clinical knowledge;
- (4) on the List of Covered Dental Procedures contained in this Policy; and
- (5) the most Appropriate and Professionally Adequate level of service or supply which can be provided on a cost effective basis without adversely affecting the Covered Person's dental condition;
- (6) the least costly professionally acceptable type of service that will adequately treat the condition; and
- (7) not primarily for aesthetic purposes.

Necessary Dental Procedures include the Diagnostic and Preventive Services contained in the List of Covered Dental Procedures contained in this Policy.

The fact that a person's Dentist prescribes a service or supply does not automatically mean that such services or supplies are considered as Necessary Dental Procedures and are covered by this Policy.

NON-PARTICIPATING DENTIST means a Dentist who is not participating in the dental network being made available through this Policy.

OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible Employees to purchase or make changes in their Employee or Dependent Dental Coverage.

Participation in an Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period or Benefit Waiting Periods.

ORTHODONTIC TREATMENT means the use of active appliances to move and correct the position of maloccluded or malpositioned teeth. Orthodontic treatment includes:

- (1) the orthodontic treatment plan and all records;
- (2) the fabrication and insertion of fixed appliances;
- (3) periodic visits and ongoing treatment and adjustments; and
- (4) the retention phase, including periodic visits and passive appliances.

Orthodontic Treatment also includes x-rays, surgical and non-surgical procedures, anesthesia, and other services related to orthodontic care.

PARTICIPATING DENTIST means a Dentist who:

- (1) has signed a contract with the dental network being made available through this Policy; and
- (2) has agreed to abide by the rules of that network.

It is the Covered Employee's responsibility to verify whether the Dentist is a Participating Dentist at the time of service. Participating Dentists are independent contractors; they are not employees or agents of the network or the Company. The Company does not supervise, control or guarantee the services of the Participating Dentist or any other Dentist.

PAYROLL PERIOD means that period of time established by the Group Policyholder for payment of employee wages. A Payroll Period may be weekly, biweekly, semimonthly or monthly.

POLICY means this group dental policy issued by the Company to the Group Policyholder.

DEFINITIONS **(continued)**

PROFESSIONALLY ADEQUATE (includes **ADEQUATE**) means the least expensive form of treatment, within the range of Appropriate Treatments, for a given dental condition, that conforms to the accepted standards of dentistry.

REGULAR PART-TIME EMPLOYEE means an employee of the [Group Policyholder or Participating Employer] who is:

- (1) regularly scheduled to work at least the number of hours shown in the Schedule of Benefits/ 20 hours each week;
- (2) a member of a class which is eligible for coverage under this Policy;
- (3) not a temporary or seasonal employee; and
- (4) a citizen of the United States or legally working in the United States.

RETIREE means a former [full-time] Employee of the [Group Policyholder or Participating Employer] who is eligible for retirement benefits.

USUAL AND CUSTOMARY (U&C) means the maximum expense covered by this Policy. U&C allowances are based on dental charge information collected by nationally recognized industry databases. U&C allowances are reviewed and updated periodically.

If Covered Expenses are Incurred outside the United States, the U&C allowance will be the amount that would be allowed for that procedure if it had been performed at the Company's Group Insurance Service Office in Omaha, Nebraska.

U&C allowances may be higher or lower than the fees charged by a Dentist. U&C is not an indication of the appropriateness of the Dentist's fee. Instead, U&C is a variable plan provision used to determine the extent of coverage provided by this Policy.

ELIGIBILITY AND EFFECTIVE DATES FOR EMPLOYEE DENTAL COVERAGE

ELIGIBILITY. An Employee becomes eligible for the coverage provided by this Policy on the [latest of]:

- (1) the Policy's date of issue;
- (2) the date coverage for a Participating Employer becomes effective, if employed by that Participating Employer ; or
- (3) the date the Eligibility Waiting Period is completed.

[The Eligibility Waiting Period is shown in the Schedule of Benefits.]

ENROLLMENT. An Employee may enroll for Employee Dental Coverage only:

- (1) when first eligible;
- (2) during any Annual Enrollment Period; or
- (3) within 31 days following a qualifying Change In Family Status, provided the change in coverage is consistent with the new family status.

EFFECTIVE DATE. Employee Dental Coverage becomes effective on the latest of:

- (1) the date the Employee becomes eligible for the coverage;
- (2) the date the Employee resumes Active Work, if not Actively at Work on the day he or she becomes eligible. The Employee will be deemed Actively at Work on any regular non-working day, if he or she:
 - (a) is not totally disabled or hospital confined on that day; and
 - (b) was Actively at Work on the regular working day before that day;
- (3) if the Employee contributes to the cost of the Employee Dental Coverage, the date the Employee makes written application for coverage; and signs:
 - (a) a payroll deduction order, if Covered Employees pay any part of the Policy premium for Employee Dental Coverage; or
 - (b) an order to pay premiums from the Employee's Section 125 Plan account, if any contributions are paid through a Section 125 Plan;and pays the first month's premium to the Company; or
- (4) the date the Company approves a Late Entrant's application.

Any increase in coverage or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date on which the Covered Employee becomes eligible for the increase, if Actively at Work on that day; or
- (2) the day the Covered Employee resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any reduction in coverage or benefits will take effect on the day of the change, whether or not the Covered Employee is Actively at Work.

ANNUAL ENROLLMENT PERIOD. An Employee again becomes eligible to enroll, re-enroll, or change benefit options for Employee Dental Coverage under this Policy during the Group Policyholder's Annual Enrollment Period. Any unsatisfied Benefit Waiting Period(s) [and/or Late Entrant Limitation Periods] will apply to coverage elected or changed during the Annual Enrollment Period. An Employee who terminates coverage under this Policy and subsequently re-enrolls during an Annual Enrollment Period will again be subject to the Policy's Benefit Waiting Period(s) [and/or Late Entrant Limitation Periods].

TERMINATION OF EMPLOYEE DENTAL COVERAGE

TERMINATION. An Employee's coverage will terminate on the earliest of:

- (1) the date this Policy is terminated (see the Policy Termination section);
- (2) the last day of the Coverage Month in which the Covered Employee requests termination of coverage;
- (3) the date through which premium has been paid on the Covered Employee's behalf;
- (4) the end of the period for which the last required premium has been paid;
- (5) the date the Covered Employee ceases to be in a class of Employees which is eligible for coverage under this Policy;
- (6) with respect to a benefit for a specific type of dental service, the date the portion of this Policy providing benefits for that type of service terminates; or
- (7) the date the Covered Employee's employment with the Group Policyholder terminates.

CONTINUATION OF COVERAGE. Ceasing Active Work results in termination of coverage; but Employee and Dependent Dental Coverage may be continued as follows.

DISABILITY. If the Covered Employee is disabled due to illness or injury; then coverage may be continued until the earliest of:

- (1) the date coverage has been continued for three Coverage Months after the disability begins;
- (2) the date the Covered Employee is no longer disabled; or
- (3) the date coverage would otherwise terminate, if the Covered Employee had remained an Active Employee;

provided premium payments are made on the Covered Employee's behalf.

FAMILY OR MEDICAL LEAVE. If the Covered Employee goes on an approved Family or Medical Leave and is **not** entitled to any more favorable continuation available during disability, then coverage may be continued until the earliest of:

- (1) the end of the leave period approved by the Employer;
- (2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
- (3) the date the Covered Employee notifies the Employer that he or she will not return; or
- (4) the date the Covered Employee begins employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

LAY-OFF OR LEAVE OF ABSENCE. If the Covered Employee ceases work due to a temporary layoff or an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); then coverage may be continued:

- (1) for three Coverage Months after the layoff or leave of absence begins;
- (2) provided premium payments are made on the Covered Employee's behalf.

If an Employee's coverage is continued as provided above, but Dependent Dental Coverage is terminated; then any Dependents who are re-enrolled at a later date will be treated as Late Entrants.

MILITARY LEAVE OF ABSENCE/TERMINATION OF EMPLOYMENT DUE TO MILITARY SERVICE. If a Covered Employee goes on leave for military service of more than 30 days, Dental Coverage may be continued[:

- (1) for up to 18 Coverage Months, if the leave begins prior to December 10, 2004; or
- (2) for up to 24 Coverage Months, if the leave begins on or after December 10, 2004;]

subject to payment of premiums.

**TERMINATION OF
EMPLOYEE DENTAL COVERAGE**
(continued)

REINSTATEMENT OF COVERAGE. The Company will reinstate Dental Coverage and waive any Eligibility Waiting Period, new Late Entrant Limitation Period, or new Benefit Waiting Period if:

- (1) a Covered Employee's coverage ends due to termination of employment or reduction of hours, and he or she returns to qualifying [full-time] employment within six months of that event[; or]
- (2) a Covered Employee goes on an approved leave of absence, (other than for an approved Family or Medical Leave or for a Military Leave), and he or she returns to qualifying full-time employment within six months of that event[; or]
- (3) a Covered Employee returns from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law[; or]
- (4) a Covered Employee's coverage ends due to military service of more than 30 days, and he or she applies for or returns to qualifying [full-time] employment:
 - (a) by the 14th day after completing military service of 31 to 180 days;
 - (b) by the 90th day after completing military service of 181 days or longer; or
 - (c) within 2 years if disabled upon completing such military service.

The Employee's accumulated leave for military service may not exceed 5 years; except as provided by federal law.

To reinstate coverage, the Employee must enroll within 31 days after resuming Active Work; sign a payroll deduction order or Section 125 Plan election, if required; and pay the first month's premium to the Company. Coverage will become effective as shown in the Effective Date section of this Policy. An Employee who resumes Active Work or enrolls later will be treated as a new Employee.

ELIGIBILITY FOR DEPENDENT DENTAL COVERAGE

DEPENDENT means a person who is a Covered Employee's:

- (1) legal spouse, who is not legally separated from the Covered Employee;
- (2) unmarried child less than 19 years of age; [or]
- (3) [unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or
- (4)] unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability; and
 - (b) chiefly dependent upon the Covered Employee for support and maintenance.

The child must be covered by the Group Policyholder's dental plan on the day before coverage would otherwise end due to his or her age. Proof of the total disability must be sent to the Company upon request. The premium will continue at the dependent rate.

"Child" includes:

- (1) a Covered Employee's natural child or legally adopted child;
- (2) a child placed with the Covered Employee for the purpose of adoption, from the date of placement;
- (3) a child for whom the Covered Employee is required by court order to provide dental coverage;
- (4) a stepchild who resides in the Covered Employee's household; and who is chiefly dependent on the Covered Employee for support; and
- (5) a foster child:
 - (a) who resides in the Covered Employee's household;
 - (b) who is chiefly dependent on the Covered Employee for support; and
 - (c) for whom the Covered Employee has assumed full parental responsibility and control.

ELIGIBILITY. A Covered Employee becomes eligible to enroll for Dependent Dental Coverage on the latest of:

- (1) the date the Covered Employee becomes eligible for Employee Dental Coverage;
- (2) the issue date of this Policy; or
- (3) the date the Covered Employee first acquires a Dependent.

A Covered Employee again becomes eligible to enroll for Dependent Dental Coverage under this Policy:

- (1) within 31 days following a qualifying Change in Family Status; or
- (2) during any Annual Enrollment Period.

[Any [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Period(s)] will apply.]

An Employee must be covered for Employee Dental Coverage to cover his or her Dependents. [Dependents to be covered by this Policy must be enrolled in the same plan of benefits as the Covered Employee.]

ANNUAL ENROLLMENT PERIOD. An Employee again becomes eligible to enroll, re-enroll, or change benefit options for Dependent Dental Coverage under this Policy during the Group Policyholder's Annual Enrollment Period. [Any unsatisfied [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods] will apply to coverage elected or changed during the Annual Enrollment Period.] [If an Employee terminates Dependent Dental Coverage under this Policy and subsequently re-enrolls during an Annual Enrollment Period, the Dependents will again be subject to the Policy's [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods].]

EFFECTIVE DATES FOR DEPENDENT DENTAL COVERAGE

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Dental Coverage will become effective on the latest of:

- (1) the first day of the Coverage Month coinciding with or next following the date the Covered Employee becomes eligible for Dependent Dental Coverage;
- (2) the first day of the Coverage Month coinciding with or next following the date the Covered Employee makes written application for Dependent Dental Coverage; and, if additional premium is required, the Employee signs:
 - (a) a payroll deduction order, if the Covered Employee pays any part of the premium for Dependent Dental Coverage; or
 - (b) an order to pay premiums from the Employee's Section 125 Plan account, if any contributions for Dependent Dental Coverage are paid through a Section 125 Plan account;and pays the first month's Dependent premium to the Company; or
- (3) the first day of the Coverage Month coinciding with or next following the date the Company approves a Late Entrant application for each Dependent applying for Dependent Dental Coverage.

COURT ORDERED COVERAGE. If coverage is provided to a child based on a court order which requires the Covered Employee to provide dental benefits for the child, the coverage will become effective on the date stated in the court order; subject to payment of any additional premium.

NEW DEPENDENTS. If a Covered Employee acquires a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) the Employee completes a written application; and
 - (2) if additional premium is required, a payroll deduction order or Section 125 Plan election is made and any additional premium is paid to the Company;
- within 31 days of the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If a Covered Employee acquires a newborn Dependent child, the child will be automatically covered for the first 90 days following birth. If the Covered Employee elects not to enroll the newborn child and pay any additional premium within 90 days following birth, the newborn child's coverage will terminate.

However, any [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods] will be waived for such Dependent child if the Covered Employee elects to enroll the child and pay the applicable premium at any time prior to or within 31 days following the child's third (3rd) birthday.

TERMINATION OF DEPENDENT DENTAL COVERAGE

TERMINATION. Dental Coverage on a Dependent will cease on the date he or she ceases to be an eligible Dependent, as defined in this Policy.

Dependent Dental Coverage will cease for all of the Covered Employee's Dependents on the earliest of:

- (1) the date the Covered Employee's Dental Coverage terminates;
- (2) the date Dependent Dental Coverage is discontinued under this Policy;
- (3) the date the Covered Employee ceases to be in a class of employees eligible for Dependent Dental Coverage;
- (4) the date the Covered Employee requests that the Dependent Dental Coverage be terminated;
- (5) with respect to a benefit for a specific type of dental service, the date the portion of this Policy providing benefits for that type of service terminates; or
- (6) the date through which premium has been paid on behalf of the covered Dependents.

SURVIVING DEPENDENTS. If Employee Dental Coverage terminates due to the Covered Employee's death, Dependent Dental Coverage may be continued:

- (1) for three Coverage Months; or any longer period, if required by state or federal law;
- (2) provided the Group Policyholder submits the premium on behalf of the surviving Dependents; and this Policy remains in force.

REINSTATEMENT OF DEPENDENT COVERAGE. The Company will reinstate a Dependent's Dental Coverage and waive any Eligibility Waiting Period, new Late Entrant Limitation Period, or new Benefit Waiting Period if a Dependent's coverage ends due to the Covered Employee's:

- (1) termination of employment or reduction of hours, and the Covered Employee returns to qualifying [full-time] employment within six months of that event[; or]
- (2) approved leave of absence, (other than for an approved Family or Medical Leave or for a Military Leave), and the Covered Employee returns to qualifying [full-time] employment within six months of that event[; or]
- (3) return from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law[; or]
- (4) military service of more than 30 days, and the Covered Employee applies for or returns to qualifying [full-time] employment:
 - (a) by the 14th day after completing military service of 31 to 180 days;
 - (b) by the 90th day after completing military service of 181 days or longer; or
 - (c) within 2 years if disabled upon completing such military service.

The Employee's accumulated leave for military service may not exceed 5 years; except as provided by federal law.

To reinstate coverage, the Covered Employee must enroll eligible Dependents within 31 days after resuming Active Work; sign a payroll deduction order or Section 125 Plan election, if required, and pay the first month's Dependent premium to the Company.

PREMIUMS AND PREMIUM RATES

PAYMENT OF PREMIUMS. No coverage provided by this Policy will be in effect until the first premium for such coverage is paid. For coverage to remain in effect, each subsequent premium must be paid on or before its due date. The Group Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at the Company's Group Insurance Service Office.

GRACE PERIOD. A grace period of 31 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the grace period, unless the Group Policyholder gives the Company advance written notice of termination. The Group Policyholder will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

PREMIUM RATE CHANGE. The Company may change any premium rate:

- (1) the date this Policy's terms are changed; or
- (2) the date the Company's liability is changed due to a change in federal, state or local law;
- (3) the date the Company's liability is changed because the Group Policyholder (or any covered division, subsidiary or affiliated company) relocates, dissolves or merges, or is added to or removed from this Policy;
- (4) the date any coverage for one or more classes ceases to be provided under this Policy;
- (5) when the number of Employees covered by this Policy changes by 15% or more from the number covered on this Policy's effective date or the most recent anniversary; [or]
- [(6) when the number of Employees covered under each plan of benefits offered by this Policy changes by 10% or more from the number covered on this Policy's effective date or the most recent anniversary; or]
- (7) on any premium due date after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 31 days' advance written notice of any increase in premium rates.

PREMIUM AMOUNT. The amount of premium due on each due date will be the total of the premium amounts obtained by multiplying:

- (1) each rate shown in the Premium Rate Schedule; by
 - (2) the number of employee and family units covered[;
- and then adding the monthly billing fee, if any].

For premium purposes, the effective date of any change in coverage is the first day of the Coverage Month which coincides with or follows the change. Changes will not be pro-rated daily.

PREMIUM RATE SCHEDULE

Plan 1

Monthly <u>Employee</u> Only Dental Rate	\$.xx per unit
Monthly <u>Employee</u> plus Dependents Dental Rate	.zz per family unit

Plan 2

Monthly <u>Employee</u> Only Dental Rate	\$.aa per unit
Monthly <u>Employee</u> plus Dependents Dental Rate	.bb per family unit

The above rates are guaranteed until 00/00/0000, unless any of the Policy's terms or the Company's liability are changed, as described in parts 1 through 7 of the PREMIUM RATE CHANGE section, above.

After that, any increase in premium will be as shown in the renewal letter.

POLICY TERMINATION

TERMINATION BY THE COMPANY. To terminate this Policy, the Company must give the Group Policyholder at least 31 days' advance written notice of its intent to do so. The Company may terminate coverage if:

- (1) the number of Covered Employees is less than ten;
- (2) part of the premium is paid by Covered Employees or through a Section 125 plan; and for Employee Dental Coverage, less than 75% of the eligible Employees are covered [(or less than 60% of eligible employees with dependents are insured for any dependent dental coverage)];
- (3) all of the premium is paid from the Group Policyholder's general funds[:]
[(a)] for Employee coverage; and less than 100% of eligible Employees are covered by the Policy[; or]
[(b)] for Employee and Dependent Coverage; and less than 100% of eligible Employees and Dependents are covered by this Policy];
- (4) the Group Policyholder, without good cause, fails to:
 - (a) promptly furnish any information which the Company may reasonably require;
 - (b) perform its duties pertaining to this Policy in good faith;
- (5) the Company terminates all other policies where permitted by their terms which provide dental benefits in the same state in which this Policy was issued; or
- (6) state law otherwise requires this Policy to be terminated.

In determining the above participation rates, "eligible employees" will not include any employee who declines to enroll because it would result in duplicate coverage [:

- (1)] under this Policy as an employee and a dependent at the same time [; or][.]
- [(2)] under this Policy and another group dental plan with his or her spouse's employer.]

TERMINATION BY GROUP POLICYHOLDER. The Group Policyholder may terminate this Policy at any time by giving the Company advance written notice. Coverage will then terminate:

- (1) on the date the Company receives the notice; or
- (2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination.

AUTOMATIC TERMINATION. If any premium remains unpaid at the end of the Grace Period; then this Policy will automatically terminate, without any action on the Company's part, on the last day of the Grace Period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

DENTAL EXPENSE BENEFITS

BENEFIT. The Company will pay Dental Expense Benefits if a Covered Person incurs Covered Expenses in excess of the Deductible during a Calendar Year. The Company will pay the Percentage Payable shown in the Schedule of Benefits for that type of service; provided any Benefit Waiting Period is satisfied. Benefits will be paid up to the Maximum shown in the Schedule of Benefits for each Covered Person.

BENEFIT DETERMINATION. The amount of benefits payable for Type 1, 2 and 3 Procedures will be determined as follows:

- (1) Dates of service are reviewed and categorized by:
 - (a) services prior to effective date;
 - (b) services after termination date; and
 - (c) covered services by benefit period or calendar year.
- (2) Each procedure, service or supply is evaluated to ensure that it qualifies as a Necessary Dental Procedure which is determined to be Professionally Adequate under the terms of the Policy.
- (3) Covered Expenses are determined, and are reduced by any unmet Deductible amount.
- (4) Then, each remaining expense for each covered service is multiplied by the Percent Payable for that type of service, to determine the Dental Expense Benefits payable, subject to Policy provisions, maximums, limitations and exclusions.

Benefits for Covered Expenses are based on Dental Necessity. Services which are determined to be not Necessary are not covered by this Policy, even if they are recommended or provided by a Dentist.

DEDUCTIBLE. The Deductible shown in the Schedule of Benefits is the amount of Covered Expenses which must be incurred before benefits are payable. The Deductible applies separately to the Covered Expenses Incurred by each Covered Person. Benefits will be based on those Covered Expenses which are in excess of the Deductible.

[After Covered Expenses Incurred by all covered family members combined exceed the Family Deductible shown in the Schedule of Benefits, no additional Covered Expenses will be applied toward the Deductible in that Calendar Year.]

[Covered Expenses Incurred and applied toward the Deductible during the last three months of a Calendar Year may be used to satisfy the Deductible for the next Calendar Year.]

BENEFIT WAITING PERIODS. The Benefit Waiting Periods are shown on the Schedule of Benefits pages of this Policy.

LATE ENTRANT LIMITATION PERIODS. The Late Entrant Limitation Periods are shown on the Schedule of Benefits pages of this Policy.

ALTERNATIVE PROCEDURES

There may be two or more methods of treating a dental condition. The amount of Covered Expense will be limited to the charge for the least costly procedure or treatment which:

- (1) the dental profession recognizes to be Professionally Adequate, in accord with accepted standards of dental practice; and
- (2) the Company determines to be both Adequate and Appropriate, in view of the Covered Person's total current oral condition.

To determine its liability for a dental procedure submitted for consideration, the Company may request the pre-operative dental x-rays and any other pertinent information. Based on its review of this information, the Company will decide which procedure would provide Professionally Adequate restoration, replacement or treatment.

The Covered Person may receive the more expensive procedure or treatment. However, the Company's liability for Covered Expense will be limited to the least expensive procedure which it determines to be Professionally Adequate care.

To find out in advance what charges or alternative procedures will be considered Covered Expenses, a Covered Person may use the Dental Claim Procedure for Predetermination of Benefits, described in this Policy.

DENTAL EXPENSE BENEFITS
[ORTHODONTICS FOR CHILDREN/FAMILY ORTHODONTICS]

BENEFITS FOR TYPE 4 SERVICES. The Company will pay Dental Expense Benefits for Orthodontic Treatment if a [Covered Person/covered Dependent Child]:

- (1) [begins/receives] Orthodontic Treatment while covered for Type 4 services (Orthodontics), under this Policy; and
- (2) incurs [initial] Covered Expenses for Orthodontic Treatment after any Benefit Waiting Period or Late Entrant Limitation Period is satisfied.

The Company will pay the Percentage Payable shown in the Schedule of Benefits for Type 4 services.

Benefits will be paid up to the Maximum shown in the Schedule of Benefits during the [Covered Person's/covered Dependent Child's] lifetime; but only for Covered Expenses Incurred while covered under this Policy.

[The Lifetime Maximum will be reduced, on a prorated basis, for orthodontic treatment received before the [Covered Person/covered Dependent Child] was covered for Type 4 services, including services received while the [Covered Person/covered Dependent Child] was in a Benefit Waiting Period or Late Entrant Limitation Period.]

BENEFIT WAITING PERIOD. The Benefit Waiting Period for Type 4 services (Orthodontics) is shown on the Schedule of Benefits page. Benefits for Type 4 services begun before, or received during, this Benefit Waiting Period will not be payable.

LATE ENTRANT LIMITATION PERIOD. The Late Entrant Limitation Period for Type 4 services (Orthodontics) is shown on the Schedule of Benefits page. Benefits for Type 4 services begun before or received during this Late Entrant Limitation Period will not be payable.

BENEFIT PAYMENTS. Orthodontic Treatment is assumed to be provided in accord with a Treatment Plan.

- (1) Covered Expenses will be based upon the estimated cost and duration of the Treatment Plan; and
- (2) Benefit payments will be pro-rated over the expected duration of the Treatment Plan, as long as the [Covered Person/covered Dependent Child] remains covered by the orthodontic benefit provision of this Policy, subject to the Lifetime Maximum for Type 4 Procedures shown on the Schedule of Benefits.

TREATMENT PLAN means a related series of orthodontic services prescribed by a Dentist to correct a specific dental condition.

PREDETERMINATION OF BENEFITS. To find out in advance what benefits will be payable for orthodontic treatment, see the Dental Claims Procedure for Predetermination of Benefits.

LIMITATIONS AND EXCLUSIONS

Except as required by law, Covered Expenses will not include, and Dental Expense Benefits will not be payable, for:

- (1) any procedure begun:
 - (a) before the Covered Person was covered under this Policy, subject to the Prior Plan Credit provision [and the Continuity of Coverage provision], if included in this Policy; or
 - (b) after termination of the Covered Person's coverage under this Policy.
- (2) treatment or service which:
 - (a) is not recommended by a Dentist or is not provided by or under the direct supervision of a Dentist;
 - (b) is not a Necessary Dental Procedure, required for the care and treatment of a dental condition, as determined by the Company;
 - (c) is not specifically listed as covered by this Policy;
 - (d) does not meet accepted standards of dental practice; or
 - (e) is provided by a physician or other health care provider, but is beyond the scope of his or her license.
- (3) charges which exceed Covered Expenses, as defined in this Policy. Benefits will not be payable when:
 - (a) total benefit payments would exceed the Annual or Lifetime Maximums payable under this Policy; or
 - (b) services exceed the frequency limitations contained on the List of Covered Dental Procedures in this Policy.
- (4) procedures which are subject to [Benefit Waiting Periods] [or] [Late Entrant Limitation Periods], until those [Benefit Waiting Periods] [or] [Late Entrant Limitation Periods] have been satisfied.
- (5) Orthodontic (Type 4) services:
 - (a) [which begin/received] before the Dependent child becomes covered under this Policy for orthodontic services, subject to the Prior Plan Credit provision [and the Continuity of Coverage provision], if included in this Policy;
 - (b) [which begin/received] during a [Benefit Waiting Period] [or] [a Late Entrant Limitation Period], subject to the Prior Plan Credit provision [and the Continuity of Coverage provision], if included in this Policy;
 - (c) received after the Dependent child's coverage ends[, due to attainment of the maximum age, or for any other reason]; or
 - (d) received after coverage for Type 4 services is terminated under this Policy.
- (6) any treatment or services which:
 - (a) are for mainly cosmetic purposes (including but not limited to bleaching of teeth; veneers; and porcelain, composite, or resin-based restorations or prosthetics for posterior teeth, except as specifically shown in the List of Covered Dental Procedures included in this Policy); or
 - (b) are related to the repair or replacement of any prior cosmetic procedure.
- (7) services related to:
 - (a) congenital or developmental malformations, including congenitally missing teeth, unless required by state law; or
 - (b) the replacement of third molars (wisdom teeth).
- (8) bone grafts or any regenerative procedure in an extraction site.

LIMITATIONS AND EXCLUSIONS
(Continued)

- (9) except as specifically shown in the List of Covered Dental Procedures included in this Policy, any procedure associated with the placement, restoration, or removal of a dental implant, and any related expenses. Related expenses may include but are not limited to:
 - (a) periodontal services which would not have been performed if the implant had not been planned and/or installed; and
 - (b) any resulting increase in charges for services covered by this Policy that are related to the dental implant.
- (10) any procedure related to a dental disease or Injury to natural teeth or bones of the jaw that is considered a covered service under any group medical plan.
- (11) orthognathic recording, orthognathic surgery, osteoplasty, osteotomy, LeFort procedures, stomatoplasty, computed tomography imaging (CT scans) or magnetic resonance imaging (MRIs).
- (12) initial placement of any prosthetic appliance; unless such placement is needed to replace one or more natural teeth extracted while the Covered Person is covered under this Policy, subject to the Prior Plan Credit provision [and the Continuity of Coverage provision], if included in this Policy. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.
- (13) the adjustment, recementation, reline, rebase, replacement or repair of cast restorations, crowns and prostheses, within 6 months of the completion of the service.
- (14) the replacement of any major restorative services—including, but not limited to, crowns, inlays, onlays, bridges, and dentures—within the time periods shown in the List of Covered Dental Procedures from the date of the last placement of these items. If a replacement is required because of an accidental dental Injury sustained while the Covered Person is covered under this Policy, it will be a Covered Expense. If services related to the Injury are covered by the Covered Person's group medical plan, those charges should be submitted to the medical plan first.
- (15) specialized procedures, including:
 - (a) precision or semi-precision attachments;
 - (b) precious metals for removable appliances;
 - (c) overlays and overdentures; or
 - (d) personalization or characterization.
- (16) duplicate prosthetics or appliances, or for initial placement or replacement of athletic mouth guards, night guards; and, except as specifically included in the List of Covered Dental Procedures contained in this Policy, bruxism appliances or any appliance to correct harmful habits; and for replacement of:
 - (a) space maintainers; or
 - (b) broken, misplaced, lost or stolen dental appliances.
- (17) appliances, restorations or procedures, or their modifications, that:
 - (a) alter vertical dimension;
 - (b) restore or maintain occlusion or for occlusal adjustment or equilibration;
 - (c) stabilize teeth;
 - (d) replace tooth structure lost as a result of erosion, abfraction, abrasion or attrition; or
 - (e) surgically or non-surgically treat disturbances of the temporomandibular joint (TMJ), or other craniomandibular or temporomandibular disorders, except as required by law or as specifically shown in the List of Covered Dental Procedures.

LIMITATIONS AND EXCLUSIONS
(Continued)

- (18) charges for services provided by:
 - (a) an ambulatory surgical facility;
 - (b) a hospital;
 - (c) any other facility; or
 - (d) an anesthesiologist.
- (19) except as specifically shown in the List of Covered Dental Procedures included in this Policy, analgesia, sedation, hypnosis or acupuncture, for anxiety or apprehension.
- (20) any medications administered outside the Dentist's office or for prescription drugs.
- (21) except as specifically shown in the List of Covered Dental Procedures included in this Policy, charges which do not directly provide for the diagnosis or treatment of a dental Injury or condition, such as:
 - (a) the completion of claim forms;
 - (b) broken appointments;
 - (c) interest or collection charges;
 - (d) sales taxes, except where required by law, or other taxes or surcharges;
 - (e) education, training and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control;
 - (f) [caries susceptibility tests,] [bacteriologic studies,] [oral cancer screenings,] [histopathologic exams] [or pulp vitality testing;]
 - (g) copying of x-rays or other dental records; or
 - (h) duplication of services.
- (22) itemized or separated charges for dental services, supplies or materials when those services, supplies and materials may be combined into a single, more comprehensive procedure payable under this Policy. This also includes itemized charges which are routinely included in the Dentist's charge for the primary service, such as:
 - (a) sterilization or asepsis charges;
 - (b) a charge for local anesthesia or analgesia, including nitrous oxide;
 - (c) charges for pre- and post-operative care;
 - (d) temporary or provisional dental services (for example, a temporary crown), which are considered to be part of the permanent service, except for interim dentures to replace teeth extracted while covered by this Policy.
- (23) charges for which the Covered Person is not liable, or which would not have been made had no coverage been in force.
- (24) a Covered Person's dental Injury or condition:
 - (a) for which he or she is eligible for benefits under Workers' Compensation or any similar law;
 - (b) arising out of, or in the course of, work for wage or profit; or
 - (c) sustained while performing military service.
- (25) services received for dental conditions caused directly or indirectly by:
 - (a) war or an act of war;
 - (b) intentionally self-inflicted Injury;
 - (c) engaging in an illegal occupation;
 - (d) commission or attempt to commit a felony; or
 - (e) a Covered Person's active participation in a riot.

LIMITATIONS AND EXCLUSIONS
(Continued)

- (26) scaling and root planing, or other periodontal treatment; unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish Dental Necessity for treatment.
- (27) more than one detailed or extensive oral evaluation per Dentist for a Covered Person while covered by this Policy or any replacement policy.

COORDINATION OF DENTAL EXPENSE BENEFITS

EFFECT ON BENEFITS. If a Covered Person is covered by another Plan, the Dental Expense Benefits under this Policy and benefits under the other Plan(s) will be coordinated for the Claim Period. The Order of Benefit Determination Rules on the next page decide which Plan pays first.

- (1) **Primary Benefits.** When this Plan must pay its full benefits first, the Dental Expense Benefits under this Policy will be paid as if the other coverage did not exist.
- (2) **Secondary Benefits.** When another Plan must pay its full benefits first, the Dental Expense Benefits under this Policy:
 - (a) will be calculated as if the other coverage did not exist; and then
 - (b) will be reduced so that total benefits, from all Plans combined, will not exceed 100% of the Allowable Expenses incurred by the Claimant during that Claim Period.

Benefits will be coordinated with any benefit amounts that would be payable for the Allowable Expenses under the other Plan(s), whether or not claim is actually made. When this Plan's benefits are reduced, each benefit is reduced in proportion. Then, the reduced benefit payments are applied towards the Maximums of this Plan.

BENEFIT SAVINGS. The amount by which this Plan's benefits have been reduced due to such coordination will accrue during the Claim Period. This amount will be used to pay any Allowable Expenses which:

- (1) are incurred by that Claimant during the same Claim Period; and
- (2) are not otherwise paid by any Plan.

DEFINITIONS. The following definitions apply only to this coordination provision.

"Plan" means any group insurance or group type coverages (whether insured or uninsured), which provide medical or dental care benefits or services. This includes but is not limited to:

- (1) Blue Cross and Blue Shield plans;
- (2) blanket (other than school accident coverage) and franchise insurance plans;
- (3) Health Maintenance Organization (HMO) and Dental Maintenance Organization (DMO) plans; and
- (4) other prepayment, group practice and individual practice plans.

It also includes any coverage under a government medical or dental plan required or provided by law; except Medicaid. This Plan must pay its benefits before Medicaid pays. Coordination with Medicare will be in accord with federal law.

Each of the above coverages is a separate Plan. If an arrangement has two or more parts, and its coordination provision applies only to some benefits or services; then each part is a separate plan.

"Allowable Expense" means any necessary, Usual and Customary expense for dental care, which is at least partly covered under at least one of the Plans covering the Claimant. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered during the Claim Period will be considered Allowable Expense.

"Claimant" means the Covered Person for whom claim is made.

"Claim Period" means a calendar year (or part of a calendar year) during which the Claimant has been covered under this Policy.

DENTAL COVERAGE CONTINUATION

The following provisions comply with the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. These provisions apply when Dental Coverage is provided by a private Employer with 20 or more employees (as defined by COBRA). Any further changes made to the COBRA continuation requirements will automatically apply to these continuation provisions.

RIGHT TO CONTINUE. Insurance may be continued in accord with the following provisions when:

- (1) a Covered Person becomes ineligible for Policy coverage due to a Qualifying Event shown below; and
- (2) this Policy remains in force.

"Qualifying Event," as it applies to a Covered Employee, means the Covered Employee's termination of employment, hours reduction or retirement, if it would otherwise result in a Qualified COBRA Beneficiary's loss of Policy coverage.

"Qualifying Event," as it applies to a Covered Dependent, means one of the following events, if it would otherwise result in a Qualified COBRA Beneficiary's loss of Policy coverage:

- (1) the Covered Employee's termination of employment, retirement or hours reduction;
- (2) the Covered Employee's death, divorce or legal separation;
- (3) the Covered Employee's becoming entitled to Medicare benefits; or
- (4) a child's ceasing to be an eligible Covered Dependent, under the terms of this Policy.

"Qualified Beneficiary" means the Covered Employee and any Covered Dependent who is entitled to continue insurance under this Policy, from the date of the Covered Employee's first Qualifying Event. It also includes the Covered Employee's natural child, legally adopted child or child placed for the purpose of adoption; when the new child:

- (1) is acquired during the Covered Employee's 18- or 29-month continuation period; and
- (2) is enrolled for insurance in accord with the terms of this Policy.

But it does **not** include the Covered Employee's new spouse, stepchild or foster child acquired during that continuation period; whether or not the new Dependent is enrolled for Policy coverage.

CONTINUATION PERIODS. The maximum period of continued coverage for each Qualifying Event shall be as follows.

Termination of Employment. When eligibility ends due to the Covered Employee's termination of employment; then coverage for the Covered Employee and any Covered Dependents may be continued for up to 18 months, from the date employment ended. Termination of employment includes a reduction in hours or retirement. **Exceptions:**

- (1) **Misconduct.** If the Covered Employee's termination of employment is for gross misconduct, coverage may **not** be continued for the Covered Employee or any Covered Dependents.
- (2) **Disability.** "Disability" or "Disabled" as used in this section, shall be as defined by Title II or XVI of the Social Security Act and determined by the Social Security Administration.

If the Covered Employee:

- (a) becomes disabled by the 60th day after his or her employment ends; and
 - (b) is covered for Social Security Disability Income benefits;
- then coverage for the Covered Employee and any Covered Dependents may be continued for up to 29 months, from the date the Covered Employee's employment ended.

If the Covered Employee's Dependent:

- (a) becomes disabled by the 60th day after the Covered Employee's employment ends; and
 - (b) is covered for Social Security Disability Income benefits;
- then coverage for the Covered Employee and any Covered Dependents may be continued for up to 29 months, from the date the Covered Employee's employment ended.

DENTAL COVERAGE CONTINUATION (continued)

The Covered Employee must send the Company a copy of the Social Security Administration's notice of disability status:

- (a) within 60 days after they find that the Covered Person is disabled, and before the 18-month continuation period expires; and again
- (b) within 30 days after they find that he or she is no longer disabled.

(3) **Subsequent Qualifying Event.** If the Covered Employee's Dependent:

- (a) is a Qualified Beneficiary; and
- (b) has a subsequent Qualifying Event during the 18- or 29-month continuation period;

then coverage for that Covered Dependent may be continued for up to 36 months, from the date the Covered Employee's employment ended.

Loss of Dependent Eligibility. If a Covered Dependent's eligibility ends, due to a Qualifying Event **other than** the Covered Employee's termination of employment; then that Dependent's coverage may be continued for up to 36 months, from the date of the event. Such events may include:

- (1) the Covered Employee's death, divorce, legal separation, or Medicare entitlement; and
- (2) a child's reaching the age limit, getting married or ceasing to be a full-time student.

One or more subsequent Qualifying Events may occur during the Covered Dependent's 36-month period of continued coverage; but coverage may not be continued beyond 36 months, from the date of the first Qualifying Event.

Medicare Entitlement. If the Covered Employee's eligibility under this Policy ends due to a Qualifying Event and he or she becomes entitled to Medicare after electing COBRA continuation coverage, then coverage may not be continued for the Covered Employee. Coverage may be continued for any Covered Dependents for up to 36 months from date of the first Qualifying Event.

If the Covered Employee's eligibility under this Policy continues beyond Medicare entitlement, but later ends due to a Qualifying Event; then any Covered Dependents may continue coverage for up to:

- (1) 36 months from the Covered Employee's Medicare entitlement date; or
- (2) 18 months from the date of the first Qualifying Event (whichever is later).

Coverage may not be continued beyond 36 months, from the date of the first Qualifying Event.

NOTICE REQUIREMENTS. The Group Policyholder is required by law to notify the Company within 30 days after the following Qualifying Events:

- (1) the Covered Employee's termination of employment, hours reduction or retirement; and
- (2) the Covered Employee's death or becoming entitled to Medicare benefits.

The Covered Employee or other Qualified Beneficiary:

- (1) must notify the Group Policyholder within 60 days after the later of:
 - (a) the date of a divorce; a legal separation; or a child's ceasing to be an eligible Dependent, as defined by this Policy; or
 - (b) the date the coverage would end as a result of one of these events; and
- (2) must notify the Company within 60 days of the Social Security Administration's finding that a Covered Person was disabled within 60 days after the Covered Employee's termination of employment.

ELECTION. To continue Dental Insurance, the Covered Person must notify the Group Policyholder of such election within 60 days from the latest of:

- (1) the date of the Qualifying Event;
- (2) the date coverage would otherwise end due to the Qualifying Event; or
- (3) the date the Group Policyholder sends notice of the right to continue.

Payment for the cost of the insurance for the period prior to the election must be made to the Group Policyholder, within 45 days after the date of such election. Subsequent payments are to be made to the Group Policyholder, in the manner described by the Group Policyholder. The Group Policyholder will remit all payments to the Company.

DENTAL COVERAGE CONTINUATION
(continued)

TERMINATION. Continued coverage will end at the earliest of the following dates:

- (1) the end of the maximum period of continued coverage shown above;
- (2) the date this Policy or the Employer's participation under this Policy terminates;
- (3) the last day of the period of coverage for which premium has been paid, if any premium is not paid when due;
- (4) the date on which:
 - (a) the Covered Person again becomes covered under this Policy;
 - (b) the Covered Employee becomes entitled (covered) for benefits under Medicare;
or
 - (c) the Covered Person becomes covered under any other group dental plan, as an employee or otherwise.

OTHER CONTINUATION PROVISIONS. If any other continuation privilege is available to the Covered Person under this Policy, it will apply as follows.

- (1) **FMLA.** If a Covered Employee continues coverage during leave subject to the Family and Medical Leave Act (FMLA); then COBRA continuation may be elected from the day after the FMLA continuation period ends.
- (2) **Other.** If a Covered Person continues coverage under any other continuation privilege under this Policy; then that continuation period will run concurrently with any COBRA continuation period provided above.

Another continuation privilege may provide a shorter continuation period, for which the Employer pays all or part of the premium. In that event, the Covered Person's share of the premium may increase for the rest of the COBRA continuation period provided above.

CONTINUITY OF COVERAGE

ELIGIBILITY. A Covered Person is eligible for credit upon transfer from another employer's group dental plan if the Schedule of Benefits shows that the Continuity of Coverage provision applies and:

- (1) the Employee:
 - (a) is covered under a previous employer's group dental plan within 31 days before Dental Expense Benefits under this Policy take effect for such Employee and coverage with the group dental plan terminates; and
 - (b) immediately becomes covered under this dental plan on the earliest day that the Dental Expense Benefits under this Policy can take effect.
- (2) the Employee's Dependent:
 - (a) is covered under an employer's group dental plan within 31 days before Dental Expense Benefits under this Policy take effect and coverage with the group dental plan terminates;
 - (b) immediately becomes covered under this dental plan on the earliest day that the Dental Expense Benefits under this Policy can take effect; and
 - (c) the Employee is covered for Group Dental Expense Benefits under this Policy.

EFFECT OF CONTINUITY OF COVERAGE ON BENEFITS. If this provision applies, then the Covered Person's Dental Expense Benefits will be payable as follows.

- (1) Any amounts used to satisfy the Covered Person's Deductible under the prior plan will be credited toward the satisfaction of his or her Deductible under this Policy; provided:
 - (a) the expenses would be Covered Expenses under this Policy;
 - (b) the expenses are incurred during the same [Calendar/Policy/Plan] Year in which Dental Expense Benefits under this Policy take effect; and
 - (c) the Covered Person sends the Company a claim worksheet explaining the benefits paid by the prior plan.
- [(2) Orthodontia Benefits paid by the prior plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under this Policy.]
- (3) The Covered Person's continuous months of coverage under the prior plan just before it terminated will count toward this Policy's Benefit Waiting Period for Type 2 Procedures (Basic Care) [or Type 3 services (Major Care)], if any.
- [(4) The Covered Person's continuous months of coverage under the prior plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under this Policy; but only if both the prior group dental plan and this Policy provide orthodontia benefits.]
- [(5) Expense that the Covered Person incurs for initial placement of a prosthetic appliance or fixed bridge will be covered; provided:
 - (a) the placement is needed to replace one or more natural teeth extracted while insured for Dental Expense Benefits under this Policy or under the prior group dental plan;
 - (b) the replacement would have been covered under the prior plan; and
 - (c) the extracted teeth are not third molars (wisdom teeth).]

PRIOR PLAN CREDIT

ELIGIBILITY. A Covered Person is eligible for Prior Plan Credit if:

- (1) the Schedule of Benefits shows that the Prior Plan Credit provision applies;
- (2) the Dental Expense Benefits under this Policy replace a Prior Plan; and
- (3) the Covered Person immediately becomes covered under this dental plan on the day the [Group Policyholder's/Participating Employer's], affiliate's, or acquired company's Dental Expense Benefits under this Policy take effect.

EFFECT OF PRIOR PLAN CREDIT ON BENEFITS. If this provision applies, then the Covered Person's Dental Expense Benefits will be payable as follows.

- (1) Any amounts used to satisfy the Covered Person's Deductible under the Prior Plan will be credited toward the satisfaction of his or her Deductible under this Policy; provided:
 - (a) the expenses would be Covered Expenses under this Policy;
 - (b) the expenses are incurred during the same [Calendar/Policy/Plan] Year in which Dental Expense Benefits under this Policy take effect; and
 - (c) the Covered Person sends the Company a claim worksheet explaining the benefits paid by the Prior Plan.
- [(2) Orthodontia Benefits paid by the Prior Plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under this Policy.]
- (3) The Covered Person's continuous months of coverage under the Prior Plan just before it terminated will count toward this Policy's Benefit Waiting Period for Type 2 Procedures (Basic Care) [or Type 3 services (Major Care)], if any.
- [(4) The Covered Person's continuous months of coverage under the Prior Plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under this Policy; but only if both the Prior Plan and this Policy provide orthodontia benefits.]
- [(5) Expense that the Covered Person incurs for initial placement of a prosthetic appliance or fixed bridge will be covered; provided:
 - (a) the placement is needed to replace one or more natural teeth extracted while insured for Dental Expense Benefits under this Policy or under the Prior Plan;
 - (b) the replacement would have been covered under the Prior Plan; and
 - (c) the extracted teeth are not third molars (wisdom teeth).]

DEFINITION

"Prior Plan" means:

- (1) the [Group Policyholder's/Participating Employer's] Prior Group Dental Plan; or
- (2) the Prior Dental Plan of an affiliate or an entity acquired by the Group Policyholder after the Policy's effective date;

which this Policy replaced:

- (1) within 1 day of the Prior Plan's termination date; or
- (2) within 60 days of the Prior Plan's termination date, if the Employer has more than 15 Covered Employees under this Policy on its effective date.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 1 PROCEDURES - DIAGNOSTIC & PREVENTIVE SERVICES**

- **ROUTINE ORAL EXAMINATIONS**
 - * up to two per calendar year
 - * includes comprehensive evaluation, no more than one per Dentist in 3 years
- **DENTAL X-RAYS**
 - * x-rays taken for orthodontia are not covered under this provision
 - **Bitewing films**
 - * up to four per calendar year, including any bitewings taken as part of a full mouth series
 - * includes any vertical bitewings
 - **Panoramic x-rays; or**
 - **Full mouth x-rays, with periapical x-rays and bitewings**
 - * one complete full mouth series or panoramic film, no more than once every five years
 - **Other dental x-rays**
 - * maximum of six per calendar year
- **PROPHYLAXIS (Routine Cleanings)**
 - * up to two per calendar year[, but this will be reduced by the number of periodontal maintenance cleanings that are paid in the same calendar year]
 - * [one additional routine cleaning per calendar year for Covered Persons who:
 - * are pregnant;
 - * have diabetes; or
 - * have a documented history of heart disease or strokeA doctor's statement confirming the diagnosis and the need for a more frequent cleaning must be submitted to the Company.]
 - * includes polishing of teeth and removal of plaque, calculus and stains
- **PERIODONTAL MAINTENANCE CLEANING**
 - * up to four per calendar year[, but this will be reduced by the number of routine cleanings, including routine cleanings performed for Covered Persons who are pregnant, have diabetes, or have a documented history of health disease or stroke, that are paid in the same calendar year]
 - * following active periodontal therapy
 - * not covered if performed less than 3 months following periodontal surgery
- **FLUORIDE TREATMENTS**
 - * one treatment per calendar year
 - * [for Dependent children through age 15]
 - * [for Covered Persons age 16 or older]
 - * includes fluoride varnish for high-risk patients
 - * does not include take-home or over-the-counter treatments
- **SPACE MAINTAINERS (Passive Appliance)**
 - * one appliance per site while covered under this provision
 - * for Dependent children through age 15
 - * for the purpose of maintaining spaces created by the premature loss of primary teeth
 - * includes all adjustments within six months after installation
 - * does not include repairs or replacement costs
- **SEALANTS**
 - * one treatment per tooth, no more than once in any 36-month period
 - * for Dependent children through age 15
 - * for the occlusal surface of unrestored and non-decayed first and second permanent molars only

LIST OF COVERED DENTAL PROCEDURES
TYPE 1 PROCEDURES - DIAGNOSTIC & PREVENTIVE SERVICES
(continued)

- **APPLIANCE TO INHIBIT THUMB SUCKING AND OTHER HARMFUL HABITS**
 - * one appliance while covered under this Policy
 - * for Dependent children through age 15
 - * includes all adjustments within six months after installation
 - * does not include repairs or replacement costs

- **OTHER SERVICES**
 - * each service is covered one time while covered under this Policy
 - * genetic test for susceptibility to oral diseases
 - * caries susceptibility test
 - * pulp vitality test per tooth

NOTE: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES - BASIC SERVICES**

- **SEALANTS**
 - * one treatment per tooth, no more than once in any 36-month period
 - * for Dependent children through age 15
 - * for the occlusal surface of unrestored and non-decayed first and second permanent molars only
- **EXAMINATIONS**
 - **Oral examinations**, problem-focused and/or emergency exams (other than routine periodic exams)
 - * up to 4 per calendar year
 - * Benefits are payable for an emergency examination or for emergency palliative treatment, but not both in the same visit
- **CONSULTATIONS**
 - * provided by a Dentist other than the Dentist providing any treatment
 - * payable if no other services are rendered
- **EMERGENCY TREATMENT**
 - **Emergency palliative treatment**
 - * Palliative treatment is limited to:
 - * opening and drainage of a tooth when no endodontics is to follow
 - * opening and medicating
 - * smoothing down a chipped tooth
 - * dry socket treatment
 - * pericoronitis treatment
 - * treatment for aphthous ulcers
 - Benefits are payable only if services are rendered in order to relieve dental pain or dental injury
- **INJECTION OF ANTIBIOTICS**
 - * by the Dentist, in the Dentist's office
- **FILLINGS**
 - **Filling**[, includes composite fillings]
 - * [benefits for composite fillings of posterior teeth will be limited to the amount payable for an equivalent amalgam filling]
 - * multiple restorations on the same tooth will be treated as one restoration with multiple surfaces; and multiple restorations on one surface or adjacent surfaces will be treated as one restoration
 - * replacement fillings for a tooth or tooth surface which was filled within the last 12 months are not covered
 - **Pin retention, in addition to restoration**
- **SEDATIVE FILLINGS**
 - * to relieve pain
 - * not covered if used as a base or liner under a restoration
- **PREFABRICATED STAINLESS STEEL OR RESIN CROWNS**
 - * resin crowns are covered for anterior and bicuspid teeth only
 - * replacement for a crown which was placed within the last 24 months is not covered

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES - BASIC SERVICES
(Continued)**

- **EXTRACTIONS AND ORAL SURGERY**
 - * includes local anesthesia and routine post operative visits
 - * extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
 - * extractions and surgical exposure of teeth, when related to orthodontic treatment, are not covered under this provision
- **Simple extraction**
- **Surgical removal of erupted tooth**
- **Removal of impacted tooth** (soft tissue, partially or completely bony)
- **Surgical exposure of impacted or unerupted tooth**, to aid eruption
- **EXTRACTIONS AND ORAL SURGERY**
 - * includes local anesthesia and routine post operative visits
 - * extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
 - * extractions and surgical exposure of teeth, when related to orthodontic treatment, are not covered under this provision
- **Simple extraction**
- **Surgical removal of erupted tooth**
- **Removal of impacted tooth** (soft tissue, partially or completely bony)
- **Surgical exposure of impacted or unerupted tooth**, to aid eruption
- **Excision of hyperplastic tissue**
- **Excision of pericoronal gingiva**
- **Removal of exposed roots**
- **Surgical removal of residual tooth roots**
- **Excision of lesions, malignant or benign tumors**
- **Radical resection of bone for tumor with bone graft**
- **Incision and removal of foreign body from soft tissue**
- **Removal of foreign body from bone**
- **Maxillary sinusotomy for removal of tooth fragment or foreign body**
- **Suture of soft tissue wound**
 - * excludes closure of surgical incisions
- **Incision and drainage of abscess**
- **Frenulectomy**
- **Sialolithotomy and Sialodochoplasty**
- **Dilation of salivary duct**
- **Sequestrectomy for osteomyelitis or bone abscess**
- **Closure of fistula, salivary or oroantral**
- **Reimplantation of tooth or tooth bud due to an accident**
- **Alveolectomy** (with or without extractions)
- **Vestibuloplasty**
- **Removal of exostosis of the maxilla or mandible**
 - * includes removal of tori
- **Biopsy and examination of oral tissue**
 - * includes brush biopsy [and FDA-approved oral cancer screening system]

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES - BASIC SERVICES
(Continued)**

- **ADMINISTRATION OF ANESTHESIA**
 - **General anesthesia or I.V. sedation**
 - * administered in the Dentist's office by the Dentist or other person licensed to administer anesthesia
 - * payable in connection with:
 - * a complex cutting procedure;
 - * a documented health history that would require the administration of anesthesia;
 - * a child through 6 years of age; or
 - * a physically or developmentally disabled Covered Person
 - * not covered when benefits for the accompanying surgical procedure are not payable
 - * not covered when administered due to patient anxiety
 - * anesthesia, when related to orthodontic treatment, is not covered under this provision
- **REPAIR of PROSTHETICS**
 - * no benefits are payable within six months of installation
 - **Repair of dentures**
 - * repair of complete denture includes repair of broken base and replacement of missing or broken teeth
 - * repair of partial dentures includes repair of acrylic saddles on base, cast framework, repair or replacement of broken clasp, and replacement of missing or broken teeth
 - **Repair or recementation of inlays, crowns and bridges**
- **OCCLUSAL GUARD**
 - * one in any 24-month period
- **ENDODONTICS** (treatment of diseases of root canal, periapical tissue and pulp chamber)
 - **Pulp cap**, direct or indirect
 - * not covered if done on the same day as the permanent restoration
 - **Pulpotomy**
 - * primary teeth only
 - **Gross pulpal debridement**
 - **Root canal therapy**
 - * permanent teeth only
 - * includes necessary x-rays and cultures
 - * retreatment not covered for 12 months
 - **Root canal obstruction: non-surgical treatment**
 - **Incomplete endodontic therapy, inoperable or fractured tooth**
 - **Internal root repair of perforation defects**
 - **Apexification**
 - **Apicoectomy**
 - **Root amputation**
 - **Hemisection**

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES - BASIC SERVICES
(Continued)**

- **PERIODONTICS** (treatment of disease of the soft tissue or bone surrounding the tooth)
- **PERIODONTAL SURGERY**
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
 - * surgical treatment includes post operative visits
 - * one operative session per site in any 36-month period
 - * benefits for multiple periodontal surgeries within the same quadrant on the same day will be paid based on the most comprehensive procedure provided that day
- **Gingivectomy or gingivoplasty**
- **Osseous surgery**
- **Soft tissue graft**
- **Bone replacement graft**
- **Subepithial connective tissue graft**
- **Guided tissue regeneration**
 - * not covered under this provision if performed in a site where the tooth has been extracted
- **Crown lengthening**
- **NON-SURGICAL PERIODONTAL SERVICES**
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
 - * benefit payment may be based on tooth, sextant or quadrant
- **Full-Mouth Debridement**
 - * one treatment in any 24-month period
- **Scaling and root planing**, for pathological alveolar bone loss
 - * one treatment in any 24-month period
 - * not covered if performed less than 3 months following periodontal surgery
- **Localized delivery of chemotherapeutic agent by means of a controlled release vehicle**
 - * following active periodontal therapy which has failed to resolve the condition
 - * one per tooth in any 36-month period
- **PERIODONTAL MAINTENANCE CLEANING**
 - * up to four per calendar year[, but this will be reduced by the number of routine cleanings, including routine cleanings performed for Covered Persons who are pregnant, have diabetes, or have a documented history of health disease or stroke, that are paid in the same calendar year]
 - * following active periodontal therapy
 - * not covered if performed less than 3 months following periodontal surgery
- **OCCLUSAL ADJUSTMENT**
 - * maximum of one adjustment per quadrant in any 36-month period

NOTE: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES - MAJOR SERVICES**

- **ENDODONTICS** (treatment of diseases of root canal, periapical tissue and pulp chamber)
 - **Pulp cap**, direct or indirect
 - * not covered if done on the same day as the permanent restoration
 - **Pulpotomy**
 - * primary teeth only
 - **Gross pulpal debridement**
 - **Root canal therapy**
 - * permanent teeth only
 - * includes necessary x-rays and cultures
 - * retreatment not covered for 12 months
 - **Root canal obstruction: non-surgical treatment**
 - **Incomplete endodontic therapy, inoperable or fractured tooth**
 - **Internal root repair of perforation defects**
 - **Apexification**
 - **Apicoectomy**
 - **Root amputation**
 - **Hemisection**
- **PERIODONTICS** (treatment of disease of the soft tissue or bone surrounding the tooth)
- **PERIODONTAL SURGERY**
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
 - * surgical treatment includes post operative visits
 - * one operative session per site in any 36-month period
 - * benefits for multiple periodontal surgeries within the same quadrant on the same day will be paid based on the most comprehensive procedure provided that day
 - **Gingivectomy or gingivoplasty**
 - **Osseous surgery**
 - **Soft tissue graft**
 - **Bone replacement graft**
 - **Subepithelial connective tissue graft**
 - **Guided tissue regeneration**
 - * not covered under this provision if performed in a site where the tooth has been extracted
 - **Crown lengthening**
- **NON-SURGICAL PERIODONTAL SERVICES**
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
 - * benefit payment may be based on tooth, sextant or quadrant
 - **Full-Mouth Debridement**
 - * one treatment in any 24-month period
 - **Scaling and root planing**, for pathological alveolar bone loss
 - * one treatment in any 24-month period
 - * not covered if performed less than 3 months following periodontal surgery
 - **Localized delivery of chemotherapeutic agent by means of a controlled release vehicle**
 - * following active periodontal therapy which has failed to resolve the condition
 - * one per tooth in any 36-month period
- **PERIODONTAL MAINTENANCE CLEANING**
 - * up to four per calendar year[, but this will be reduced by the number of routine cleanings, including routine cleanings performed for Covered Persons who are pregnant, have diabetes, or have a documented history of health disease or stroke, that are paid in the same calendar year]
 - * following active periodontal therapy
 - * not covered if performed less than 3 months following periodontal surgery

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES - MAJOR SERVICES
(Continued)**

- **ORAL SURGERY**
 - * includes local anesthesia and routine post operative visits
 - **Removal of exposed roots**
 - **Surgical removal of residual tooth roots**
 - **Excision of lesions, malignant or benign tumors**
 - **Radical resection of bone for tumor with bone graft**
 - **Incision and removal of foreign body from soft tissue**
 - **Removal of foreign body from bone**
 - **Maxillary sinusotomy for removal of tooth fragment or foreign body**
 - **Suture of soft tissue wound**
 - * excludes closure of surgical incisions
 - **Incision and drainage of abscess**
 - **Frenulectomy**
 - **Sialolithotomy and Sialodochoplasty**
 - **Dilation of salivary duct**
 - **Sequestrectomy for osteomyelitis or bone abscess**
 - **Closure of fistula, salivary or oroantral**
 - **Reimplantation of tooth or tooth bud due to an accident**
 - **Excision of hyperplastic tissue**
 - **Excision of pericoronal gingiva**
 - **Alveolectomy (with or without extractions)**
 - **Vestibuloplasty**
 - **Removal of exostosis of the maxilla or mandible**
 - * includes removal of tori
- **ADMINISTRATION OF ANESTHESIA**
 - **General anesthesia or I.V. sedation**
 - * administered in the Dentist's office by the Dentist or other person licensed to administer anesthesia
 - * payable in connection with:
 - * a complex cutting procedure;
 - * a documented health history that would require the administration of anesthesia;
 - * a child through 6 years of age; or
 - * a physically or developmentally disabled Covered Person
 - * not covered when benefits for the accompanying surgical procedure are not payable
 - * not covered when administered due to patient anxiety
 - * anesthesia, when related to orthodontic treatment, is not covered under this provision

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES - MAJOR SERVICES
(Continued)**

- **PROSTHODONTICS - Fixed or Removable**
Services to replace teeth extracted or accidentally lost [while covered under this Policy]
 - * includes adjustments, within six months of the placement date
 - * benefits are not payable for temporary or provisional services
- **Bridge abutments and pontics (fixed)**
 - * replacement [including/excluding a dental implant] is limited to one time in any 8 consecutive years from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury
- **Dentures, complete (upper or lower) or partial (upper or lower) or unilateral partial (removable)**
 - * fees for partial dentures include all conventional clasps, rests and teeth
 - * includes addition of teeth or clasp(s) to an existing partial denture [to replace natural teeth extracted or accidentally lost while covered under this Policy]
 - * replacement [including/excluding a dental implant] is limited to once in any 5 consecutive years, per denture, from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury, provided the existing denture is not serviceable
- **Adjustments to dentures**, more than six months after installation
- **Tissue conditioning**
 - * one per arch per calendar year
- **Reline of complete or partial denture**
 - * one per calendar year, per denture
- **Rebase of complete or partial denture**
 - * once in any 5-year period, per denture
- **Guided tissue regeneration**, at the site of an extracted tooth
 - * one per site while covered under this Policy
- **Dental implants**
 - * not covered for claimants prior to age 16
 - * implants are limited to one per tooth in any 8 consecutive years; or sooner, if a replacement is required because of an accidental dental injury sustained while the Covered Person is covered under this Policy
- **Surgical placement of implant body**
- **Implant prosthetics**
 - * implant-supported crown
 - * abutment-supported crown
 - * implant abutment (includes placement)
 - * implant-supported retainer
 - * abutment-supported retainer
- **Other implant procedures**
 - * implant maintenance procedures
 - * repair implant abutment
 - * repair implant-supported prosthesis
 - * removal of implant body
- **Bone replacement graft**, at the site of an extracted tooth
 - * one per site while covered under this Policy

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES - MAJOR SERVICES
(Continued)**

- **MAJOR RESTORATIONS**

- * inlays, onlays, veneers, and crowns are covered only when needed due to substantial loss of tooth structure caused by decay or accidental Injury to teeth
- * benefits are not payable for the placement of an inlay, onlay, veneer, or crown within 8 years since the placement date of an inlay, onlay, veneer, or crown on the same tooth, unless replacement is required due to an accidental Injury
- * benefits are not payable for temporary or provisional services
- * temporary services in place for one year or more are considered to be permanent services and are subject to this Policy's frequency limitations
- * not covered for claimants prior to age 16

- **Inlays**
- **Onlays**
- **Crowns and posts**
- **Crown build-up**, in conjunction with a payable crown
- **Cast post and core**, in conjunction with a payable crown
- **Cast post**, as part of a payable crown
- **Veneers**

- **TREATMENT OF DISORDERS OF THE TEMPOROMANDIBULAR JOINT**

- **includes anesthesia and postoperative care**
- **reduction of dislocation, open or closed**
- **manipulation under general anesthesia**
- **condylectomy**
- **excision or repair of disc**
- **synovectomy**
- **myotomy**
- **joint reconstruction**
- **arthrotomy**
- **arthroplasty**
- **arthrocentesis**
- **arthroscopy**
- **orthodontic appliances**
- **occlusal orthotic devices**

NOTE: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 4 PROCEDURES - ORTHODONTICS
(FOR DEPENDENT CHILDREN)**

- **ORTHODONTICS**

Active and passive services related to the guidance and alignment of teeth

- **Diagnostic services**
 - * **Examinations**
 - * **X-rays**
 - * **Diagnostic casts or study models**
- **Treatment plan**
- **Orthodontic extractions**
 - * includes anesthesia, if Necessary
- **Transseptal Fibrotomy**
- **Orthodontic appliances**

**LIST OF COVERED DENTAL PROCEDURES
TYPE 1 – DIAGNOSTIC & PREVENTIVE SERVICES**

SCHEDULED BENEFIT PLAN

ECP	Value	Standard	Premier
-----	-------	----------	---------

ECP= Economic Choice Plan

**DIAGNOSTIC SERVICES
ORAL EXAMINATIONS**

- up to two per calendar year

Periodic	\$18	\$22	\$25	\$27
Comprehensive	\$27	\$33	\$37	\$41

DENTAL X-RAYS

- x-rays taken for orthodontia are not covered under this provision of the Policy

Bitewing films

- up to four per calendar year, including any bitewings taken as part of a full mouth or panoramic series

2 films	\$16	\$19	\$21	\$24
4 films	\$23	\$28	\$32	\$35

Panoramic x-rays; or

Full mouth series, with periapical x-rays and bitewings

- one complete full mouth or panoramic series in any five consecutive years

Panoramic film	\$43	\$53	\$59	\$62
Intraoral-Complete Including Bitewings	\$51	\$63	\$71	\$79

Other dental x-rays, needed to diagnose a specific dental condition

- maximum of 6 per calendar year

Periapical-first film	\$10	\$12	\$13	\$15
Periapical-each additional film	\$7	\$9	\$10	\$11
Intraoral-occlusal film	\$13	\$16	\$18	\$20
Extraoral-first film	\$16	\$19	\$22	\$24

PREVENTIVE CARE

PROPHYLAXIS (Routine Cleanings)

- up to two per calendar year
- includes polishing of teeth and removal of plaque, calculus and stains

Age 16 and older	\$38	\$47	\$52	\$58
Through age 15	\$22	\$27	\$31	\$34

FLUORIDE TREATMENTS

- one treatment per calendar year for Dependent children through age 15

Including prophylaxis	\$35	\$43	\$48	\$53
Not including prophylaxis	\$14	\$18	\$20	\$22

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 1 – DIAGNOSTIC & PREVENTIVE SERVICES
(Continued)**

ECP	Value	Standard	Premier
-----	-------	----------	---------

ECP= Economic Choice Plan

SPACE MAINTAINERS (Passive Appliance)

- for Dependent children through age 15
- for the purpose of maintaining spaces created by the premature loss of primary teeth
- includes all adjustments within six months after installation

Fixed-unilateral	\$129	\$159	\$179	\$199
Fixed-bilateral	\$200	\$246	\$277	\$307

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 - BASIC SERVICES**

SCHEDULED BENEFIT PLAN

ECP	Value	Standard	Premier
-----	-------	----------	---------

ECP= Economic Choice Plan

SEALANTS:

- for Dependent children through age 15
- for the occlusal surface of unrestored and non-decayed first and second permanent molars only
- one treatment per tooth in any 36 consecutive months

Per tooth	\$16	\$20	\$23	\$25
-----------	------	------	------	------

BASIC RESTORATIONS

Fillings:

- benefits for composite fillings of posterior teeth will be limited to the amount payable for an equivalent amalgam filling
- multiple restorations on the same tooth will be treated as one restoration with multiple surfaces; and multiple restorations on one surface or adjacent surfaces will be treated as one restoration
- replacement fillings for a tooth or tooth surface which was filled within the last six months are not covered
- includes pin retention, in addition to restoration

Amalgam-1 surface primary tooth	\$33	\$41	\$46	\$51
Amalgam-2 surfaces primary tooth	\$41	\$51	\$57	\$64
Amalgam-3 surfaces primary tooth	\$50	\$61	\$69	\$76
Amalgam-1 surface permanent tooth	\$38	\$47	\$53	\$59
Amalgam-2 surfaces permanent tooth	\$47	\$58	\$66	\$73
Amalgam-3 surfaces permanent tooth	\$57	\$70	\$79	\$88
Composite-1 surface anterior tooth	\$44	\$54	\$61	\$68
Composite-2 surfaces anterior tooth	\$56	\$69	\$77	\$86
Composite-3 surfaces anterior tooth	\$68	\$84	\$94	\$105

Prefabricated stainless steel or resin crowns

- for covered Dependent children through age 15
- one per tooth, in any 5 consecutive years

Stainless steel crown-primary tooth	\$81	\$100	\$112	\$125
Stainless steel crown-permanent tooth	\$86	\$106	\$120	\$133
Resin crown	\$88	\$108	\$122	\$135
Stainless steel crown with resin	\$102	\$125	\$141	\$157

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 - BASIC SERVICES
(Continued)**

ECP	Value	Standard	Premier
-----	-------	----------	---------

ECP= Economic Choice Plan

ORAL SURGERY

- oral surgery includes local anesthesia and routine post operative visits
- extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
- where related to orthodontic treatment, extractions and surgical exposure of teeth are not covered under this provision

Simple extraction

Single tooth	\$42	\$51	\$58	\$64
Each additional tooth	\$39	\$48	\$54	\$60

Surgical removal of erupted tooth

With mucoperiosteal flap	\$77	\$95	\$107	\$119
--------------------------	------	------	-------	-------

Removal of impacted tooth

Soft tissue impaction	\$98	\$121	\$136	\$151
Partially bony impacted	\$128	\$158	\$177	\$197
Completely bony impacted	\$150	\$185	\$208	\$231

Surgical exposure of tooth, to aid eruption

Exposure of impacted or unerupted tooth	\$120	\$147	\$166	\$184
-----------------------------------------	-------	-------	-------	-------

Excision of hyperplastic tissue

Per arch	\$147	\$181	\$204	\$227
----------	-------	-------	-------	-------

Excision of pericoronal gingiva

	\$58	\$71	\$80	\$89
--	------	------	------	------

Removal of exposed roots

Root Removal	\$53	\$65	\$73	\$81
--------------	------	------	------	------

Surgical removal of residual tooth roots

Surgical removal	\$82	\$101	\$114	\$127
------------------	------	-------	-------	-------

Excision of lesions, malignant or benign tumors

Radical excision-up to 1.25 cm diameter	\$165	\$203	\$229	\$254
Benign tumor-up to 1.25 cm diameter	\$133	\$164	\$184	\$205

Incision and removal of foreign body from soft tissue

Remove foreign body	\$72	\$89	\$100	\$111
---------------------	------	------	-------	-------

Removal of foreign body from bone

Remove foreign body	\$134	\$166	\$186	\$207
---------------------	-------	-------	-------	-------

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 - BASIC SERVICES
(Continued)**

ECP	Value	Standard	Premier
-----	-------	----------	---------

ECP = Economic Choice Plan

ORAL SURGERY (continued)

Maxillary sinusotomy for removal of tooth fragment or foreign body

Remove tooth fragment or foreign body	\$509	\$626	\$704	\$783
---------------------------------------	-------	-------	-------	-------

Suture of soft tissue wound

- excludes closure of surgical incisions

Recent wounds, up to 5 cm	\$56	\$69	\$78	\$87
---------------------------	------	------	------	------

Incision and drainage of abscess

Intraoral soft tissue	\$50	\$62	\$70	\$77
-----------------------	------	------	------	------

Frenulectomy

Frenulectomy or frenulotomy	\$115	\$141	\$159	\$176
-----------------------------	-------	-------	-------	-------

Sialolithotomy / Sialodochoplasty

Sialolithotomy	\$220	\$271	\$305	\$338
----------------	-------	-------	-------	-------

Sequestrectomy for osteomyelitis or bone abscess

Sequestrectomy	\$106	\$130	\$146	\$162
----------------	-------	-------	-------	-------

Closure of fistula

Salivary	\$400	\$492	\$554	\$615
Oral antral	\$434	\$534	\$601	\$667

Reimplantation

Tooth or tooth bud	\$141	\$174	\$196	\$217
--------------------	-------	-------	-------	-------

EMERGENCY TREATMENT

Emergency examination and palliative treatment

Palliative treatment is limited to:

- opening and drainage of a tooth when no endodontics is to follow
- smoothing down a chipped tooth
- dry socket treatment
- pericoronitis treatment
- treatment for apthous ulcers

Benefits for emergency treatment are payable only if services are rendered in order to relieve dental pain or dental injury

Emergency palliative treatment	\$29	\$36	\$40	\$45
--------------------------------	------	------	------	------

CONSULTATIONS

- provided by a Dentist other than the Dentist providing any treatment
- payable if no other services are rendered

Consultation-diagnostic services only	\$34	\$41	\$47	\$52
---------------------------------------	------	------	------	------

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 - BASIC SERVICES
(Continued)**

ECP	Value	Standard	Premier
-----	-------	----------	---------

ECP= Economic Choice Plan

ADMINISTRATION OF ANESTHESIA

General anesthesia or I.V. sedation

- administered in the Dentist's office by the Dentist or other person licensed to administer anesthesia
- payable in connection with a Necessary complex oral surgery procedure
- payable when underlying medical condition, age or health factors render anesthesia medically necessary
- not covered when benefits for the accompanying surgical procedure are not payable
- not covered when administered due to patient anxiety
- anesthesia for orthodontic procedures (or for procedures to treat craniomandibular or temporomandibular joint disorders, where required by state law) is not covered under this provision of this Policy

General Anesthesia-First 30 Minutes	\$122	\$150	\$169	\$187
Each Additional 15 Minutes	\$43	\$53	\$60	\$66
IV Sedation	\$128	\$157	\$177	\$196

PATHOLOGY

Biopsy and examination of oral tissue

Histopathology exam	\$47	\$58	\$65	\$72
Biopsy of oral soft tissue	\$83	\$102	\$114	\$127

REPAIR OF PROSTHETICS

- no benefits are payable within six months of installation if the repair is provided by the same Dentist who installed the prosthetic

Repair of dentures

Broken Complete Denture Base	\$45	\$56	\$63	\$70
Complete Denture-Missing/Broken Tooth	\$38	\$47	\$53	\$59
Repair Resin Denture Base	\$45	\$55	\$62	\$69
Repair Cast Framework	\$54	\$66	\$75	\$83
Repair/Replace Broken Clasp	\$58	\$72	\$80	\$89
Replace Broken Tooth-Per Tooth	\$40	\$49	\$55	\$61
Re-cement Fixed Partial Denture	\$38	\$47	\$53	\$58
Repair of Fixed Partial Denture	\$82	\$101	\$113	\$126

Repair or re-cementation of inlays, crowns and bridges

Re-cement Space Maintainer	\$21	\$26	\$30	\$33
Re-cement Inlay	\$28	\$34	\$39	\$43
Re-cement Crown	\$28	\$34	\$38	\$42

OTHER BASIC SERVICES

Injection of antibiotics

- by the Dentist, in the Dentist's office

Injection	\$20	\$24	\$28	\$31
-----------	------	------	------	------

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES**

SCHEDULED BENEFIT PLAN

ECP	Value	Standard	Premier
ECP=Economic Choice Plan			

ENDODONTICS (treatment of diseases of root canal, periapical tissue and pulp chamber)

Pulp Cap – Direct

- does not include final restoration
- indirect pulp cap not covered

Pulp Cap–Direct	\$11	\$14	\$15	\$17
-----------------	------	------	------	------

Pulpotomy

- primary teeth only

Therapeutic Pulpotomy	\$27	\$33	\$38	\$42
-----------------------	------	------	------	------

Root canal therapy

- permanent teeth only
- includes necessary x-rays and cultures

Anterior tooth, excluding final restoration	\$118	\$145	\$163	\$181
Bicuspid, excluding final restoration	\$142	\$174	\$196	\$218
Molar, excluding final restoration	\$183	\$225	\$254	\$282
Retreatment of previous root canal, more than one year after initial treatment				
-Anterior tooth	\$159	\$196	\$221	\$245
-Bicuspid	\$184	\$227	\$255	\$283
-Molar	\$217	\$267	\$300	\$333

Apexification

Apexification/recalcification-initial visit	\$51	\$62	\$70	\$78
---------------------------------------------	------	------	------	------

Apicoectomy

Apicoectomy/periradicular surgery				
• Anterior tooth	\$131	\$162	\$182	\$202
• Bicuspid-1 root	\$146	\$180	\$202	\$225
• Molar–1 root	\$158	\$195	\$219	\$243
• Each additional root	\$55	\$68	\$76	\$85

Root amputation

Retrograde Filling-Per Root	\$35	\$44	\$49	\$55
Root Amputation-Per Root	\$78	\$97	\$109	\$121

Hemisection

Includes Root Removal; without Root Canal	\$64	\$78	\$88	\$98
-------------------------------------------	------	------	------	------

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES
(Continued)**

ECP	Value	Standard	Premier
-----	-------	----------	---------

ECP = Economic Choice Plan

PERIODONTICS (treatment of disease of the soft tissue or bone surrounding the tooth)

- periodontal therapy is not covered unless bone and attachment loss is 4 mm or greater, by quadrant; and confirmed by x-rays and pocket depth charting for each tooth
- surgical treatment includes post operative visits
- benefits for multiple periodontal surgeries within the same quadrant on the same day will be paid based on the most comprehensive procedure provided that day

Gingivectomy or gingivoplasty

Per quadrant	\$90	\$110	\$124	\$138
Per tooth	\$28	\$34	\$39	\$43

Osseous or mucogingival surgery

- one per quadrant in each 36 consecutive months

Osseous surgery including flap entry and closure-per quadrant	\$197	\$242	\$272	\$303
---------------------------------------------------------------	-------	-------	-------	-------

Soft tissue graft

Pedicle soft tissue graft	\$145	\$178	\$200	\$223
Free soft tissue graft, including donor site	\$155	\$191	\$215	\$239

Bone replacement graft

First site in quadrant	\$84	\$103	\$116	\$129
Each additional site in quadrant	\$70	\$86	\$97	\$107

Subepithial connective tissue graft

Tissue graft	\$181	\$223	\$251	\$279
--------------	-------	-------	-------	-------

Guided tissue regeneration

Resorbable barrier, per site	\$96	\$119	\$134	\$148
Nonresorbable barrier, per site	\$114	\$140	\$157	\$175

Crown lengthening

Hard tissue-per tooth	\$135	\$166	\$187	\$208
-----------------------	-------	-------	-------	-------

Debridement

- one treatment per quadrant in each 24 consecutive months

Full Mouth Debridement To Enable Evaluation and Diagnosis	\$26	\$32	\$36	\$40
--------------------------------------------------------------	------	------	------	------

Please Note: Benefits are payable for categories of service, shown in **Bold**. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES
(Continued)**

ECP	Value	Standard	Premier
ECP = Economic Choice Plan			

Chemotherapeutics, for areas of refractory disease

localized delivery of chemotherapeutic agent by means of a controlled release vehicle

- following active periodontal therapy which has failed to resolve the condition
- does not include irrigation

Chemotherapeutics	\$21	\$26	\$29	\$33
-------------------	------	------	------	------

Provisional Splinting

Intracoronaral	\$55	\$68	\$76	\$85
Extracoronaral	\$52	\$64	\$72	\$80

MAJOR RESTORATIONS

Crowns and posts

- not covered for claimants prior to age 16
- covered only when needed due to substantial loss of tooth structure caused by decay or accidental injury to teeth, which cannot be repaired by fillings
- replacement of crowns is limited to one time in any eight years

Resin Crown	\$71	\$88	\$99	\$110
Porcelain/Ceramic Substrate	\$213	\$262	\$294	\$327
Porcelain Crown Fused to Predominantly Base Metal	\$180	\$221	\$249	\$276
Porcelain Crown Fused To Noble Metal	\$189	\$232	\$262	\$291
Full Cast Crown-Predominantly Base Metal	\$178	\$219	\$246	\$274
Full Cast Crown with Noble Metal	\$186	\$229	\$257	\$286

- the following services may be covered, subject to Necessity

Core Buildup, Including Pins	\$46	\$56	\$63	\$70
Cast Post & Core In Addition To Crown	\$66	\$81	\$92	\$102
Prefab Post & Core In Addition To Crown	\$58	\$71	\$80	\$89

Inlays and onlays

- Inlays and onlays are covered only when needed due to substantial loss of tooth structure caused by decay or accidental injury to teeth, which cannot be repaired by fillings
- replacement of inlays and onlays is limited to one time in any eight years

Inlay-Metallic-3 or More Surfaces	\$177	\$218	\$245	\$273
Inlay-Porcelain/Ceramic-3 or More Surfaces	\$171	\$210	\$237	\$263
Inlay-Resin Based Composite-3 or More Surfaces	\$151	\$186	\$209	\$232
Onlay-Metallic-3 Surfaces	\$187	\$230	\$259	\$288
Onlay-Porcelain/Ceramic-3 Surfaces	\$188	\$232	\$261	\$289
Onlay-Resin-Based Composite-3 Surfaces	\$176	\$217	\$244	\$271

Please Note: Benefits are payable for categories of service, shown in **Bold**. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES
(Continued)**

ECP	Value	Standard	Premier
ECP=Economic Choice Plan			

ORAL SURGERY - ALVEOLAR OR GINGIVAL RECONSTRUCTION

Alveolectomy / Alveoplasty

With extractions-per quadrant	\$38	\$47	\$53	\$58
Without extractions-per quadrant	\$80	\$99	\$111	\$123

Vestibuloplasty

Ridge extension	\$369	\$454	\$511	\$568
-----------------	-------	-------	-------	-------

Removal of exostosis of the maxilla or mandible

- includes removal of tori

Maxilla or Mandible	\$207	\$254	\$286	\$318
---------------------	-------	-------	-------	-------

PROSTHODONTICS - Fixed or Removable

Services to replace teeth extracted or accidentally lost while covered under this Policy

- precision attachments, overdentures, specialized techniques and characterizations are not covered

Bridge abutments and pontics

- replacement is limited to one time in any eight consecutive years

Pontic-Cast Noble Metal	\$186	\$229	\$258	\$286
Pontic-Porcelain Fused To Noble Metal	\$183	\$226	\$254	\$282
Pontic-Resin with Noble Metal	\$187	\$230	\$259	\$288

Dentures

- includes adjustments, within six months of the placement date
- replacement is limited to once in any five consecutive years, per denture, if the denture cannot be made serviceable.
- fees for partial dentures include all conventional clasps, rests and teeth

Complete denture

Complete Denture-Maxilla	\$232	\$286	\$321	\$357
Complete Denture-Mandible	\$228	\$281	\$316	\$351

Partial denture - upper or lower

- acrylic base or predominantly base cast with acrylic saddles

Maxilla Partial Denture-Resin Base	\$174	\$215	\$241	\$268
Mandible Partial Denture-Resin Base	\$208	\$256	\$288	\$320
Maxillary Partial Denture-Cast Metal Frame with Resin	\$260	\$320	\$360	\$401
Mandible Partial Denture-Cast Metal Frame	\$261	\$321	\$362	\$402

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES
(Continued)**

ECP	Value	Standard	Premier
ECP = Economic Choice Plan			

Removable unilateral partial denture

one piece, predominantly base casting, clasp attachments (including pontics)	\$332	\$409	\$460	\$511
------------------------------------------------------------------------------	-------	-------	-------	-------

Adjustments to dentures, more than six months after installation

Complete Upper Denture	\$12	\$15	\$17	\$19
Complete Lower Denture	\$12	\$15	\$17	\$19
Partial Upper Denture	\$14	\$17	\$19	\$21
Partial Lower Denture	\$13	\$16	\$18	\$20

Special tissue conditioning

- one per arch per calendar year

Maxillary Tissue Conditioning	\$23	\$28	\$32	\$35
-------------------------------	------	------	------	------

Reline of complete or partial denture

- once in any 36 consecutive months, per denture

Complete Maxillary Denture Chairside	\$49	\$60	\$68	\$76
Complete Mandibular Denture Chairside	\$50	\$61	\$69	\$77

Rebase of complete or partial denture

- once in any five consecutive years, per denture

Complete Upper Denture	\$88	\$108	\$122	\$135
Complete Lower Denture	\$89	\$109	\$123	\$137
Upper Partial Denture	\$86	\$106	\$120	\$133

Addition of teeth or clasp(s) to existing partial denture to replace natural teeth extracted or accidentally lost while covered under this Policy

Tooth To Existing Partial Denture	\$29	\$36	\$41	\$45
Add Clasp To Existing Partial Denture	\$36	\$44	\$49	\$55

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 4 - ORTHODONTICS**

SCHEDULED BENEFIT PLAN

ECP	Value	Standard	Premier
-----	-------	----------	---------

ECP= Economic Choice Plan

ORTHODONTICS

Active and passive services related to the guidance and alignment of teeth

Diagnostic services

Examinations

X-rays

Diagnostic casts or study models

Treatment plan

Orthodontic extractions

- includes anesthesia, if necessary

Orthodontic appliances

MAXIMUM BENEFIT

	\$500	\$750	\$1,000	\$1,500
SERVICE				
Initial visit, including all diagnostics	\$40	\$60	\$80	\$120
Monthly visits	\$20	\$30	\$40	\$60

Maximum benefit includes benefits paid for orthodontia-related x-rays, extractions and other related services.

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If the Covered Person's dentist recommends a procedure not specifically shown above, the Covered Person may call Client Services at the number shown on the Covered Person's ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of this Policy.

SCHEDULE OF BENEFITS

DENTAL PREFERRED PROVIDER ORGANIZATION (PPO).

This plan is designed to provide high quality dental care while managing the cost of the care. To do this, you are encouraged to seek dental care from Dentists who have signed a contract with the dental network being offered by the Policy. These Dentists are called Participating Dentists.

Use of a Participating Dentist is voluntary. You may receive treatment from any Dentist you choose. And you are free to change Dentists at any time. But, your out-of-pocket expenses for covered services are usually lower when the services are provided by a Participating Dentist.

A Directory of Participating Dentists is available from your Employer. Information about Participating Dentists is included on your ID card. When you enroll Eligible Dependents, two ID cards will be provided.

When using a Participating Dentist, you must present the ID Card. Most Participating Dentists prepare the necessary claim forms, and submit them to the Company for you. Benefits are based on the terms of the Policy.

CLASSIFICATION

Class 1	All Full-Time Employees located in a PPO service area in ZIP Code(s) 123, 456
---------	-------------------------------------------------------------------------------

ELIGIBILITY WAITING PERIOD: 30 days of continuous Active Work (For date coverage begins, refer to "Effective Date" section)

[FULL-TIME] MINIMUM HOURS: 30 hours per week.

[PART-TIME MINIMUM HOURS: 20 hours per week.]

SCHEDULE OF BENEFITS (Continued)

Eligible Class: All Full-Time Employees located in a PPO Service Area in ZIP Code(s) 123, 456

Contributions: You are required to contribute to the cost for Employee Dental Coverage. You are required to contribute to the cost for Dependent Dental Coverage.

Benefit Waiting Period:

Type 2 Procedures:	<u>3 Months</u>
Type 3 Procedures:	<u>6 Months</u>
Type 4 Procedures:	<u>24 Months</u>

The Benefit Waiting Period(s) shown for Type 2, 3, and 4 Services will not apply to persons who become covered on the Policy issue date; but only if they were covered under the Group Policyholder's prior group dental plan on the day before the Policy issue date.

Prior Plan Credits: Terms of the Prior Plan Credit provision apply for persons enrolled on the issue date of the Policy. Refer to the Prior Plan Credit provision in this Certificate.

Continuity of Coverage. Terms of the Continuity of Coverage provision apply to persons who were enrolled in another employer's group dental plan within 31 days before Dental Expense Benefits under the Policy take effect. See the Continuity of Coverage provision in this Certificate.

Late Entrant Limitation (when applicable):

Type 2 Procedures:	<u>12 Months</u>
Type 3 Procedures:	<u>12 Months</u>
Type 4 Procedures:	<u>12 Months</u>

DENTAL BENEFITS

	PPO PLAN In-Network Services	PPO PLAN Out-of-Network Services
CALENDAR YEAR DEDUCTIBLE for these Procedure Types (combined)	Types 1 & 2	Types 1, 2 & 3
INDIVIDUAL	\$25	\$25
FAMILY	\$75	\$75
PERCENT PAYABLE		
Type 1 - Diagnostic & Preventive Services	100%	80%
Type 2 - Basic Services	80%	60%
Type 3 - Major Services	50%	40%
Type 4 - Orthodontic Services	50%	50%
Type 1, 2, and 3 Benefits Based On	Negotiated Fees	70 th Percentile of Usual & Customary Allowance
CALENDAR YEAR MAXIMUM for these Procedure Types (combined)	\$1,500 Types 1, 2 & 3	\$1,000 Types 1, 2 & 3
LIFETIME MAXIMUM for Type 4 Procedures – Orthodontics	\$1,500	\$1,000

On the CLAIMS PROCEDURES page, the provision captioned "TO WHOM PAYABLE" is amended to read as follows.

TO WHOM PAYABLE. Dental Expense Benefits generally will be paid to you; unless you have assigned such benefits to the Dentist, or an overpayment has been made. However, if services are provided by a Participating Dentist, benefits are automatically assigned to that Dentist, unless the bill has been paid.

DEFINITIONS

ACTIVE WORK or ACTIVELY AT WORK means an Employee's full-time performance of all customary duties of his or her occupation at:

- (1) the Employer's place of business; or
- (2) any other business location designated by the Employer.

Unless disabled on the prior workday or on the day of absence, an Employee will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday;
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis; or
- (4) a Military Leave or an approved Family or Medical Leave that is not due to the Employee's own health condition.

ANNUAL ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Employer allows eligible Employees to purchase or make changes in their Employee or Dependent Dental Coverage.

Participation in an Annual Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period or Benefit Waiting Periods; and Late Entrant Limitations will apply.

APPROPRIATE TREATMENT (includes **APPROPRIATE**) means the range of services and supplies by which a dental condition may be treated, which falls within the accepted standards of dentistry. Appropriate Treatment may vary in techniques, materials utilized and technical complexity, as well as cost.

BENEFIT WAITING PERIOD means the period of time a Covered Person must be covered for Dental Expense Benefits -- or for a specific type of Dental Expense Benefits -- under the Policy before that type of service becomes eligible for coverage.

CHANGE IN FAMILY STATUS means a marriage, divorce, birth, death or change of employment or eligibility status or other event which qualifies under the requirements of Section 125 of the Internal Revenue Code of 1986, as amended. Change in Family Status also means the involuntary loss of comparable coverage under a spouse's employee benefit plan.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

COVERAGE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
- (2) ending at 12:00 midnight on the last day of the same calendar month;

at the Group Policyholder's primary place of business.

COVERED EMPLOYEE means an eligible Employee for whom the coverage provided by the Policy is in effect.

DEFINITIONS (continued)

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in the Policy. Covered Expenses:

- (1) for a Participating Dentist, do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the fee allowed by the Dentist's contract with the dental network;whichever is less; or
- (2) for a Non-Participating Dentist's charges, do not exceed[:
 - (a)] for Type 1, 2, or 3 procedures, the Policy's Usual and Customary allowances[; and
 - (b) for Type 4 procedures, the maximum Covered Expense, as determined by the Company].

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by the Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of the Policy.

COVERED PERSON means an eligible Employee or an eligible Dependent for whom the coverage provided by the Policy is in effect.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the Group Policyholder's place of business; when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

DEPENDENT: See the Eligibility for Dependent Dental Coverage section of the Policy.

DEPENDENT DENTAL COVERAGE means the coverage provided by the Policy for eligible Dependents.

ELIGIBILITY WAITING PERIOD means the continuous period of time that an Employee must be employed in an eligible class with the Group Policyholder, before he or she becomes eligible to enroll for coverage under the Policy.

This Eligibility Waiting Period may be waived for an Employee who qualifies for reinstatement of his or her coverage, as provided in the Policy.

EMPLOYEE means a Full-Time Employee or Regular Part-Time Employee of the Employer.

DEFINITIONS (continued)

EMPLOYEE DENTAL COVERAGE means the coverage provided by the Policy for eligible Employees.

EMPLOYER means the Group Policyholder or the Participating Employer named on the Face Page.

EXPENSES INCURRED (includes **INCURRED**). An expense is Incurred at the time a service is rendered or a supply is furnished, except that an expense is considered Incurred:

- (1) for an appliance (or change to an appliance), at the time the impression is made;
- (2) for a crown or bridge, at the time the tooth or teeth are prepared; and
- (3) for root canal therapy, at the time the pulp chamber is opened;

provided the service is completed within 90 days from the date it is begun.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:

- (1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
- (2) is taken in accord with the Employer's leave policy and the law which applies; and
- (3) does not exceed the period approved by the Employer and required by that law.

The leave period, may:

- (1) consist of consecutive or intermittent work days; or
- (2) be granted on a part-time equivalency basis.

If an Employee is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If an Employee is on an FMLA leave due to his or her own health condition on the date Policy coverage takes effect, he or she is not considered Actively at Work.

FULL-TIME EMPLOYEE means an employee of the Employer:

- (1) whose employment with the Employer is the employee's principal occupation;
- (2) who is regularly scheduled to work at such occupation at least 30 hours each week;
- (3) who is not a temporary or seasonal employee;
- (4) who is a member of an employee class which is eligible for coverage under the Policy; and
- (5) who is a citizen of the United States or who legally works in the United States.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of the Policy. [It can also mean the Participating Employer, if applicable.]

INJURY means damage to a Covered Person's mouth, teeth, appliance, or dental prosthesis due to an accident that occurs while he or she is covered by the Policy. Damage resulting from chewing or biting food or other objects is not considered to be an Injury.

LATE ENTRANT means an eligible Employee who makes written application:

- (1) more than 31 days after the Employee first becomes eligible for Employee Dental Coverage;
- (2) after Employee Dental Coverage has been cancelled; or
- (3) after Employee Dental Coverage has been terminated due to failure to pay premiums when due.

DEFINITIONS (continued)

LATE ENTRANT also means an eligible Dependent for whom written application is made:

- (1) more than 31 days after he or she first qualifies for Dependent Dental Coverage;
- (2) after the Covered Employee has requested to terminate Dependent Dental Coverage; or
- (3) after Dependent Dental Coverage has been terminated due to failure to pay premiums when due.

Exception for involuntary loss of coverage under another group dental plan. A person will not be considered a Late Entrant if, due to the existence of coverage under an employer's group dental plan, the Employee and/or any Dependents did not enroll within 31 days of becoming eligible for coverage under the Policy; and coverage under the other plan ends for one of the following reasons:

- (1) termination of the other plan by the sponsoring employer;
- (2) loss of the Employee's eligibility in the other plan due to his or her termination of employment or a change in his or her employment classification;
- (3) loss of a spouse's eligibility under the other plan due to his or her termination of employment or a change in his or her employment classification; or
- (4) loss of the Employee's or a Dependent's eligibility under the other plan due to a divorce or the death of the spouse.

This exception will not apply if:

- (1) the loss of coverage under the other dental plan is voluntary (for example, voluntary termination of coverage based on premium contribution levels or the extent of benefits provided); or
- (2) a person enrolls for coverage under the Policy more than 31 days after becoming eligible following the loss of coverage continued under COBRA.

In order to qualify for this exception, each person applying for coverage under the Employer's dental plan must:

- (1) provide proof of coverage under the spouse's prior dental plan; and
- (2) enroll for coverage and pay premiums for the Employer's plan within 31 days following loss of coverage under the other dental plan.

LATE ENTRANT LIMITATION PERIOD means the period of time a Late Entrant must be covered for a specific type of Dental Expense Benefits under the Policy before that type of service becomes eligible for coverage.

MILITARY LEAVE means a leave of absence that:

- (1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
- (2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
- (3) does not exceed the period required by that law.

DEFINITIONS (continued)

NECESSARY DENTAL PROCEDURE (includes **NECESSARY** and **DENTAL NECESSITY**) means a procedure, service or supply which the Company, or a qualified party selected by the Company, determines is:

- (1) required by, and Adequate and Appropriate for the diagnosis or treatment of a dental disease, condition or injury;
- (2) Appropriate and consistent with the symptoms and findings, or with the diagnosis and treatment of the Covered Person's dental disease, condition or injury;
- (3) provided in accord with generally accepted professional standards for dental practice, consistent with current scientific evidence and clinical knowledge;
- (4) on the List of Covered Dental Procedures contained in the Policy; and
- (5) the most Appropriate and Professionally Adequate level of service or supply which can be provided on a cost effective basis without adversely affecting the Covered Person's dental condition;
- (6) the least costly professionally acceptable type of service that will adequately treat the condition; and
- (7) not primarily for aesthetic purposes.

Necessary Dental Procedures include the Diagnostic and Preventive Services contained in the List of Covered Dental Procedures contained in the Policy.

The fact that a person's Dentist prescribes a service or supply does not automatically mean that such services or supplies are considered as Necessary Dental Procedures and are covered by the Policy.

NON-PARTICIPATING DENTIST means a Dentist who is not participating in the dental network being made available through the Policy.

OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible Employees to purchase or make changes in their Employee or Dependent Dental Coverage.

Participation in an Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period or Benefit Waiting Periods.

ORTHODONTIC TREATMENT means the use of active appliances to move and correct the position of maloccluded or malpositioned teeth. Orthodontic treatment includes:

- (1) the orthodontic treatment plan and all records;
- (2) the fabrication and insertion of fixed appliances;
- (3) periodic visits and ongoing treatment and adjustments; and
- (4) the retention phase, including periodic visits and passive appliances.

Orthodontic Treatment also includes x-rays, surgical and non-surgical procedures, anesthesia, and other services related to orthodontic care.

PARTICIPATING DENTIST means a Dentist who:

- (1) has signed a contract with the dental network being made available through the Policy; and
- (2) has agreed to abide by the rules of that network.

It is the Covered Employee's responsibility to verify whether the Dentist is a Participating Dentist at the time of service. Participating Dentists are independent contractors; they are not employees or agents of the network or the Company. The Company does not supervise, control or guarantee the services of the Participating Dentist or any other Dentist.

PAYROLL PERIOD means that period of time established by the Group Policyholder for payment of employee wages. A Payroll Period may be weekly, biweekly, semimonthly or monthly.

POLICY means this group dental policy issued by the Company to the Group Policyholder.

DEFINITIONS (continued)

PROFESSIONALLY ADEQUATE (includes **ADEQUATE**) means the least expensive form of treatment, within the range of Appropriate Treatments, for a given dental condition, that conforms to the accepted standards of dentistry.

REGULAR PART-TIME EMPLOYEE means an employee of the Employer who is:

- (1) regularly scheduled to work at least the number of hours shown in the Schedule of Benefits/ 20 hours each week;
- (2) a member of a class which is eligible for coverage under the Policy;
- (3) not a temporary or seasonal employee; and
- (4) a citizen of the United States or legally working in the United States.

RETIREE means a former [Full-Time] Employee of the [Group Policyholder/Participating Employer/Employer] who is eligible for retirement benefits.

USUAL AND CUSTOMARY (U&C) means the maximum expense covered by the Policy. U&C allowances are based on dental charge information collected by nationally recognized industry databases. U&C allowances are reviewed and updated periodically.

If Covered Expenses are Incurred outside the United States, the U&C allowance will be the amount that would be allowed for that procedure if it had been performed at the Company's Group Insurance Service Office in Omaha, Nebraska.

U&C allowances may be higher or lower than the fees charged by a Dentist. U&C is not an indication of the appropriateness of the Dentist's fee. Instead, U&C is a variable plan provision used to determine the extent of coverage provided by the Policy.

YOU (includes **YOUR**) means an eligible Employee for whom the coverage provided by the Policy is in effect.

ELIGIBILITY AND EFFECTIVE DATES FOR EMPLOYEE DENTAL COVERAGE

ELIGIBILITY. You become eligible for the coverage provided by the Policy on the [latest of]:

- (1) the Policy's date of issue;
- (2) the date coverage for a Participating Employer becomes effective, if employed by that Participating Employer; or
- (3) the date the Eligibility Waiting Period is completed.

[The Eligibility Waiting Period is shown in the Schedule of Benefits.]

ENROLLMENT. You may enroll for Employee Dental Coverage only:

- (1) when first eligible;
- (2) during any Annual Enrollment Period; or
- (3) within 31 days following a qualifying Change In Family Status, provided the change in coverage is consistent with the new family status.

EFFECTIVE DATE. Employee Dental Coverage becomes effective on the latest of:

- (1) the date you become eligible for the coverage;
- (2) the date you resume Active Work, if not Actively at Work on the day you become eligible. You will be deemed Actively at Work on any regular non-working day, if you:
 - (a) are not totally disabled or hospital confined on that day; and
 - (b) were Actively at Work on the regular working day before that day;
- (3) if you contribute to the cost of the Employee Dental Coverage, the date you make written application for coverage; and sign:
 - (a) a payroll deduction order, if you pay any part of the Policy premium for Employee Dental Coverage; or
 - (b) an order to pay premiums from your Section 125 Plan account, if any contributions are paid through a Section 125 Plan;and pay the first month's premium to the Company; or
- (4) the date the Company approves a Late Entrant's application.

Any increase in coverage or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) [the first day of the Insurance Month coinciding with or next following] the date on which you become eligible for the increase, if Actively at Work on that day; or
- (2) [the day] you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any reduction in coverage or benefits will take effect on the day of the change, whether or not you are Actively at Work.

ANNUAL ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Employee Dental Coverage under the Policy during the Group Policyholder's Annual Enrollment Period. Any unsatisfied Benefit Waiting Period(s) [and/or Late Entrant Limitation Periods] will apply to coverage elected or changed during the Annual Enrollment Period. If you terminate coverage under the Policy and subsequently re-enroll during an Annual Enrollment Period, you will again be subject to the Policy's Benefit Waiting Period(s) [and/or Late Entrant Limitation Periods].

TERMINATION OF EMPLOYEE DENTAL COVERAGE

TERMINATION. Your coverage will terminate on the earliest of:

- (1) the date the Policy is terminated;
- (2) the last day of the Coverage Month in which you request termination;
- (3) the date through which premium has been paid on your behalf;
- (4) the end of the period for which the last required premium has been paid;
- (5) the date you cease to be in a class of Employees which is eligible for coverage under the Policy;
- (6) with respect to a benefit for a specific type of dental service, the date the portion of the Policy providing benefits for that type of service terminates; or
- (7) the date your employment with the Group Policyholder terminates.

CONTINUATION OF COVERAGE. Ceasing Active Work results in termination of coverage; but Employee and Dependent Dental Coverage may be continued as follows.

DISABILITY. If you are disabled due to illness or injury; then coverage may be continued until the earliest of:

- (1) the date coverage has been continued for three Coverage Months after the disability begins;
- (2) the date you are no longer disabled; or
- (3) the date coverage would otherwise terminate, if you had remained an Active Employee; provided premium payments are made on your behalf.

FAMILY OR MEDICAL LEAVE. If you go on an approved Family or Medical Leave and are **not** entitled to any more favorable continuation available during disability, then coverage may be continued until the earliest of:

- (1) the end of the leave period approved by the Employer;
- (2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
- (3) the date you notify the Employer that you will not return; or
- (4) the date you begin employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

LAY-OFF OR LEAVE OF ABSENCE. If you cease work due to a temporary layoff or an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); then coverage may be continued:

- (1) for three Coverage Months after the layoff or leave of absence begins;
- (2) provided premium payments are made on your behalf.

If your coverage is continued as provided above, but Dependent Dental Coverage is terminated; then any Dependents who are re-enrolled at a later date will be treated as Late Entrants.

MILITARY LEAVE OF ABSENCE/TERMINATION OF EMPLOYMENT DUE TO MILITARY SERVICE. If you go on leave for military service of more than 30 days, Dental Coverage may be continued[:

- (1) for up to 18 Coverage Months, if the leave begins prior to December 10, 2004; or
 - (2) for up to 24 Coverage Months, if the leave begins on or after December 10, 2004;]
- subject to payment of premiums.

**TERMINATION OF
EMPLOYEE DENTAL COVERAGE**

REINSTATEMENT OF COVERAGE. The Company will reinstate Dental Coverage and waive any Eligibility Waiting Period, new Late Entrant Limitation Period, or new Benefit Waiting Period if:

- (1) your coverage ends due to termination of employment or reduction of hours; and you return to qualifying [full-time] employment within six months of that event[; or]
- (2) you go on an approved leave of absence, (other than for an approved Family or Medical Leave or for a Military Leave), and you return to qualifying full-time employment within six months of that event[; or]
- (3) you return from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law[; or]
- (4) your coverage ends due to military service of more than 30 days; and you apply for or return to qualifying [full-time] employment:
 - (a) by the 14th day after completing military service of 31 to 180 days;
 - (b) by the 90th day after completing military service of 181 days or longer; or
 - (c) within 2 years if disabled upon completing such military service.

Your accumulated leave for military service may not exceed 5 years; except as provided by federal law.

To reinstate coverage, you must enroll within 31 days after resuming Active Work; sign a payroll deduction order or Section 125 Plan election, if required; and pay the first month's premium to the Company. Coverage will become effective as shown in the Effective Date section of the Policy. If you resume Active Work or enroll later, you will be treated as a new Employee.

ELIGIBILITY FOR DEPENDENT DENTAL COVERAGE

DEPENDENT means a person who is your:

- (1) legal spouse, who is not legally separated from you;
- (2) unmarried child less than 19 years of age; [or]
- (3) [unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or
- (4)] unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability; and
 - (b) chiefly dependent upon you for support and maintenance.

The child must be covered by the Group Policyholder's dental plan on the day before coverage would otherwise end due to his or her age. Proof of the total disability must be sent to the Company upon request. The premium will continue at the dependent rate.

"Child" includes:

- (1) your natural child or legally adopted child;
- (2) a child placed with you for the purpose of adoption, from the date of placement;
- (3) a child for whom you are required by court order to provide dental coverage;
- (4) a stepchild who resides in your household; and who is chiefly dependent on you for support; and
- (5) a foster child:
 - (a) who resides in your household;
 - (b) who is chiefly dependent on you for support; and
 - (c) for whom you have assumed full parental responsibility and control.

ELIGIBILITY. You become eligible to enroll for Dependent Dental Coverage on the latest of:

- (1) the date you becomes eligible for Employee Dental Coverage;
- (2) the issue date of the Policy; or
- (3) the date you first acquire a Dependent.

You again become eligible to enroll for Dependent Dental Coverage under the Policy:

- (1) within 31 days following a qualifying Change in Family Status; or
- (2) during any Annual Enrollment Period.

[Any [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Period(s)] will apply.]

You must be covered for Employee Dental Coverage to cover your Dependents. [Dependents to be covered by the Policy must be enrolled in the same plan of benefits as you.]

ANNUAL ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Dependent Dental Coverage under the Policy during the Group Policyholder's Annual Enrollment Period. [Any unsatisfied [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods] will apply to coverage elected or changed during the Annual Enrollment Period.] [If you terminate Dependent Dental Coverage under the Policy and subsequently re-enroll during an Annual Enrollment Period, your Dependents will again be subject to the Policy's [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods].]

EFFECTIVE DATES FOR DEPENDENT DENTAL COVERAGE

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Dental Coverage will become effective on the latest of:

- (1) the first day of the Coverage Month coinciding with or next following the date you become eligible for Dependent Dental Coverage;
- (2) the first day of the Coverage Month coinciding with or next following the date you make written application for Dependent Dental Coverage; and, if additional premium is required, you sign:
 - (a) a payroll deduction order, if you pay any part of the premium for Dependent Dental Coverage; or
 - (b) an order to pay premiums from the Employee's Section 125 Plan account, if any contributions for Dependent Dental Coverage are paid through a Section 125 Plan account;and pay the first month's Dependent premium to the Company; or
- (3) the first day of the Coverage Month coinciding with or next following the date the Company approves a Late Entrant application for each Dependent applying for Dependent Dental Coverage.

COURT ORDERED COVERAGE. If coverage is provided to a child based on a court order which requires you to provide dental benefits for the child, the coverage will become effective on the date stated in the court order; subject to payment of any additional premium.

NEW DEPENDENTS. If you acquire a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) you complete a written application; and
- (2) if additional premium is required, a payroll deduction order or Section 125 Plan election is made and any additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically covered for the first 90 days following birth. If you elect not to enroll the newborn child and pay any additional premium within 90 days following birth, the newborn child's coverage will terminate.

However, any [Benefit Waiting Periods(s)] [and/or] [Late Entrant Limitation Periods] will be waived for such Dependent child if you elect to enroll the child and pay the applicable premium at any time prior to or within 31 days following the child's third (3rd) birthday.

TERMINATION OF DEPENDENT DENTAL COVERAGE

TERMINATION. Dental Coverage on a Dependent will cease on the date he or she ceases to be an eligible Dependent, as defined in the Policy.

Dependent Dental Coverage will cease for all of your Dependents on the earliest of:

- (1) the date your Dental Coverage terminates;
- (2) the date Dependent Dental Coverage is discontinued under the Policy;
- (3) the date you cease to be in a class of employees eligible for Dependent Dental Coverage;
- (4) the date you request that the Dependent Dental Coverage be terminated;
- (5) with respect to a benefit for a specific type of dental service, the date the portion of the Policy providing benefits for that type of service terminates; or
- (6) the date through which premium has been paid on behalf of your covered Dependents.

SURVIVING DEPENDENTS. If Employee Dental Coverage terminates due to your death, Dependent Dental Coverage may be continued:

- (1) for three Coverage Months; or any longer period, if required by state or federal law;
- (2) provided the Group Policyholder submits the premium on behalf of the surviving Dependents; and the Policy remains in force.

REINSTATEMENT OF DEPENDENT COVERAGE. The Company will reinstate your Dependent's Dental Coverage and waive any Eligibility Waiting Period, new Late Entrant Limitation Period, or new Benefit Waiting Period if a Dependent's coverage ends due to your:

- (1) termination of employment or reduction of hours, and you return to qualifying [full-time] employment within six months of that event[; or]
- (2) approved leave of absence, (other than for an approved Family or Medical Leave or for a Military Leave), and you return to qualifying [full-time] employment within six months of that event[; or]
- (3) return from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law[; or]
- (4) military service of more than 30 days, and you apply for or return to qualifying [full-time] employment:
 - (a) by the 14th day after completing military service of 31 to 180 days;
 - (b) by the 90th day after completing military service of 181 days or longer; or
 - (c) within 2 years if disabled upon completing such military service.

Your accumulated leave for military service may not exceed 5 years; except as provided by federal law.

To reinstate coverage, you must enroll eligible Dependents within 31 days after resuming Active Work; sign a payroll deduction order or Section 125 Plan election, if required, and pay the first month's Dependent premium to the Company.

DENTAL EXPENSE BENEFITS

BENEFIT. The Company will pay Dental Expense Benefits if a Covered Person incurs Covered Expenses in excess of the Deductible during a Calendar Year. The Company will pay the Percentage Payable shown in the Schedule of Benefits for that type of service; provided any Benefit Waiting Period is satisfied. Benefits will be paid up to the Maximum shown in the Schedule of Benefits for each Covered Person.

BENEFIT DETERMINATION. The amount of benefits payable for [Type 1 and 2] [Type 1, 2 and 3] Procedures will be determined as follows:

- (1) Dates of service are reviewed and categorized by:
 - (a) services prior to effective date;
 - (b) services after termination date; and
 - (c) covered services by benefit period or calendar year.
- (2) Each procedure, service or supply is evaluated to ensure that it qualifies as a Necessary Dental Procedure which is determined to be Professionally Adequate under the terms of the Policy.
- (3) Covered Expenses are determined, and are reduced by any unmet Deductible amount.
- (4) Then, each remaining expense for each covered service is multiplied by the Percent Payable for that type of service, to determine the Dental Expense Benefits payable, subject to Policy provisions, maximums, limitations and exclusions.

Benefits for Covered Expenses are based on Dental Necessity. Services which are determined to be not Necessary are not covered by this Policy, even if they are recommended or provided by a Dentist.

DEDUCTIBLE. The Deductible shown in the Schedule of Benefits is the amount of Covered Expenses which must be incurred before benefits are payable. The Deductible applies separately to the Covered Expenses Incurred by each Covered Person. Benefits will be based on those Covered Expenses which are in excess of the Deductible.

[After Covered Expenses Incurred by all covered family members combined exceed the Family Deductible shown in the Schedule of Benefits, no additional Covered Expenses will be applied toward the Deductible in that Calendar Year.]

[Covered Expenses Incurred and applied toward the Deductible during the last three months of a Calendar Year may be used to satisfy the Deductible for the next Calendar Year.]

BENEFIT WAITING PERIODS. The Benefit Waiting Periods are shown on the Schedule of Benefits pages of this Certificate.

LATE ENTRANT LIMITATION PERIODS. The Late Entrant Limitation Periods are shown on the Schedule of Benefits pages of this Certificate.

ALTERNATIVE PROCEDURES

There may be two or more methods of treating a dental condition. The amount of Covered Expense will be limited to the charge for the least costly procedure or treatment which:

- (1) the dental profession recognizes to be Professionally Adequate, in accord with accepted standards of dental practice; and
- (2) the Company determines to be both Adequate and Appropriate, in view of the Covered Person's total current oral condition.

To determine its liability for a dental procedure submitted for consideration, the Company may request the pre-operative dental x-rays and any other pertinent information. Based on its review of this information, the Company will decide which procedure would provide Professionally Adequate restoration, replacement or treatment.

The Covered Person may receive the more expensive procedure or treatment. However, the Company's liability for Covered Expense will be limited to the least expensive procedure which it determines to be Professionally Adequate care.

To find out in advance what charges or alternative procedures will be considered Covered Expenses, you may use the Dental Claim Procedure for Predetermination of Benefits, described in the Policy.

DENTAL EXPENSE BENEFITS
[ORTHODONTICS FOR CHILDREN/FAMILY ORTHODONTICS]

BENEFITS FOR TYPE 4 SERVICES. The Company will pay Dental Expense Benefits for Orthodontic Treatment if [a covered Dependent child/you or your Dependent]:

- (1) [begins/receives] Orthodontic Treatment while covered for Type 4 services (Orthodontics), under the Policy; and
- (2) incurs [initial] Covered Expenses for Orthodontic Treatment after any Benefit Waiting Period or Late Entrant Limitation Period is satisfied.

The Company will pay the Percentage Payable shown in the Schedule of Benefits for Type 4 services.

Benefits will be paid up to the Maximum shown in the Schedule of Benefits during the [Covered Person's/covered Dependent Child's] lifetime; but only for Covered Expenses Incurred while covered under the Policy.

[The Lifetime Maximum will be reduced, on a prorated basis, for orthodontic treatment received before [the Dependent Child/you or your Dependent] was covered for Type 4 services, including services received while [the Dependent Child/you or your Dependent] was in a Benefit Waiting Period or Late Entrant Limitation Period.]

BENEFIT WAITING PERIOD. The Benefit Waiting Period for Type 4 services (Orthodontics) is shown on the Schedule of Benefits page. Benefits for Type 4 services begun before, or received during, this Benefit Waiting Period will not be payable.

LATE ENTRANT LIMITATION PERIOD. The Late Entrant Limitation Period for Type 4 services (Orthodontics) is shown on the Schedule of Benefits page. Benefits for Type 4 services begun before or received during this Late Entrant Limitation Period will not be payable.

BENEFIT PAYMENTS. Orthodontic Treatment is assumed to be provided in accord with a Treatment Plan.

- (1) Covered Expenses will be based upon the estimated cost and duration of the Treatment Plan; and
- (2) Benefit payments will be pro-rated over the expected duration of the Treatment Plan, as long as [the Dependent Child/you or your Dependent] remains covered by the orthodontic benefit provision of the Policy, subject to the Lifetime Maximum for Type 4 Procedures shown on the Schedule of Benefits.

TREATMENT PLAN means a related series of orthodontic services prescribed by a Dentist to correct a specific dental condition.

PREDETERMINATION OF BENEFITS. To find out in advance what benefits will be payable for orthodontic treatment, see the Dental Claims Procedure for Predetermination of Benefits.

LIMITATIONS AND EXCLUSIONS

Except as required by law, Covered Expenses will not include, and Dental Expense Benefits will not be payable, for:

- (1) any procedure begun:
 - (a) before you or your Dependent were covered under the Policy, subject to the Prior Plan Credit provision [and the Continuity of Coverage provision], if included in the Policy; or
 - (b) after termination of your or your Dependent's coverage under the Policy.
- (2) treatment or service which:
 - (a) is not recommended by a Dentist or is not provided by or under the direct supervision of a Dentist;
 - (b) is not a Necessary Dental Procedure, required for the care and treatment of a dental condition, as determined by the Company;
 - (c) is not specifically listed as covered by the Policy;
 - (d) does not meet accepted standards of dental practice; or
 - (e) is provided by a physician or other health care provider, but is beyond the scope of his or her license.
- (3) charges which exceed Covered Expenses, as defined in the Policy. Benefits will not be payable when:
 - (a) total benefit payments would exceed the Annual or Lifetime Maximums payable under the Policy; or
 - (b) services exceed the frequency limitations contained on the List of Covered Dental Procedures in the Policy.
- (4) procedures which are subject to [Benefit Waiting Periods] [or] [Late Entrant Limitation Periods], until those [Benefit Waiting Periods] [or] [Late Entrant Limitation Periods] have been satisfied.
- (5) Orthodontic (Type 4) services:
 - (a) [which begin/received] before your Dependent child becomes covered under the Policy for orthodontic services, subject to the Prior Plan Credit provision [and the Continuity of Coverage provision], if included in the Policy;
 - (b) [which begin/received] during a [Benefit Waiting Period] [or] [a Late Entrant Limitation Period], subject to the Prior Plan Credit provision [and the Continuity of Coverage provision], if included in the Policy;
 - (c) received after your Dependent child's coverage ends[, due to attainment of the maximum age, or for any other reason]; or
 - (d) received after coverage for Type 4 services is terminated under the Policy.
- (6) any treatment or services which:
 - (a) are for mainly cosmetic purposes (including but not limited to bleaching of teeth; veneers; and porcelain, composite, or resin-based restorations or prosthetics for posterior teeth, except as specifically shown in the List of Covered Dental Procedures included in the Policy); or
 - (b) are related to the repair or replacement of any prior cosmetic procedure.
- (7) services related to:
 - (a) congenital or developmental malformations, including congenitally missing teeth, unless required by state law; or
 - (b) the replacement of third molars (wisdom teeth).
- (8) bone grafts or any regenerative procedure in an extraction site.

LIMITATIONS AND EXCLUSIONS (Continued)

- (9) except as specifically shown in the List of Covered Dental Procedures included in the Policy, any procedure associated with the placement, restoration, or removal of a dental implant, and any related expenses. Related expenses may include but are not limited to:
 - (a) periodontal services which would not have been performed if the implant had not been planned and/or installed; and
 - (b) any resulting increase in charges for services covered by the Policy that are related to the dental implant.
- (10) any procedure related to a dental disease or Injury to natural teeth or bones of the jaw that is considered a covered service under any group medical plan.
- (11) orthognathic recording, orthognathic surgery, osteoplasty, osteotomy, LeFort procedures, stomatoplasty, computed tomography imaging (CT scans) or magnetic resonance imaging (MRIs).
- (12) initial placement of any prosthetic appliance; unless such placement is needed to replace one or more natural teeth extracted while you or your Dependent is covered under the Policy, subject to the Prior Plan Credit provision [and the Continuity of Coverage provision], if included in the Policy. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.
- (13) the adjustment, recementation, reline, rebase, replacement or repair of cast restorations, crowns and prostheses, within 6 months of the completion of the service.
- (14) the replacement of any major restorative services—including, but not limited to, crowns, inlays, onlays, bridges, and dentures—within the time periods shown in the List of Covered Dental Procedures from the date of the last placement of these items. If a replacement is required because of an accidental dental Injury sustained while you or your Dependent is covered under the Policy, it will be a Covered Expense. If services related to the Injury are covered by your or your Dependent's group medical plan, those charges should be submitted to the medical plan first.
- (15) specialized procedures, including:
 - (a) precision or semi-precision attachments;
 - (b) precious metals for removable appliances;
 - (c) overlays and overdentures; or
 - (d) personalization or characterization.
- (16) duplicate prosthetics or appliances, or for initial placement or replacement of athletic mouth guards, night guards; and, except as specifically included in the List of Covered Dental Procedures contained in the Policy, bruxism appliances or any appliance to correct harmful habits; and for replacement of:
 - (a) space maintainers; or
 - (b) broken, misplaced, lost or stolen dental appliances.
- (17) appliances, restorations or procedures, or their modifications, that:
 - (a) alter vertical dimension;
 - (b) restore or maintain occlusion or for occlusal adjustment or equilibration;
 - (c) stabilize teeth;
 - (d) replace tooth structure lost as a result of erosion, abfraction, abrasion or attrition; or
 - (e) surgically or non-surgically treat disturbances of the temporomandibular joint (TMJ), or other craniomandibular or temporomandibular disorders, except as required by law or as specifically shown in the List of Covered Dental Procedures.

LIMITATIONS AND EXCLUSIONS
(Continued)

- (18) charges for services provided by:
 - (a) an ambulatory surgical facility;
 - (b) a hospital;
 - (c) any other facility; or
 - (d) an anesthesiologist.
- (19) except as specifically shown in the List of Covered Dental Procedures included in the Policy, analgesia, sedation, hypnosis or acupuncture, for anxiety or apprehension.
- (20) any medications administered outside the Dentist's office or for prescription drugs.
- (21) except as specifically shown in the List of Covered Dental Procedures included in the Policy, charges which do not directly provide for the diagnosis or treatment of a dental Injury or condition, such as:
 - (a) the completion of claim forms;
 - (b) broken appointments;
 - (c) interest or collection charges;
 - (d) sales taxes, except where required by law, or other taxes or surcharges;
 - (e) education, training and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control;
 - (f) [caries susceptibility tests,] [bacteriologic studies,] [oral cancer screenings,] [histopathologic exams] [or pulp vitality testing;]
 - (g) copying of x-rays or other dental records; or
 - (h) duplication of services.
- (22) itemized or separated charges for dental services, supplies or materials when those services, supplies and materials may be combined into a single, more comprehensive procedure payable under the Policy. This also includes itemized charges which are routinely included in the Dentist's charge for the primary service, such as:
 - (a) sterilization or asepsis charges;
 - (b) a charge for local anesthesia or analgesia, including nitrous oxide;
 - (c) charges for pre- and post-operative care;
 - (d) temporary or provisional dental services (for example, a temporary crown), which are considered to be part of the permanent service, except for interim dentures to replace teeth extracted while covered by the Policy.
- (23) charges for which you are not liable, or which would not have been made had no coverage been in force.
- (24) your or your Dependent's dental Injury or condition:
 - (a) for which you or your Dependent is eligible for benefits under Workers' Compensation or any similar law;
 - (b) arising out of, or in the course of, work for wage or profit; or
 - (c) sustained while performing military service.
- (25) services received for dental conditions caused directly or indirectly by:
 - (a) war or an act of war;
 - (b) intentionally self-inflicted Injury;
 - (c) engaging in an illegal occupation;
 - (d) commission or attempt to commit a felony; or
 - (e) your or your Dependent's active participation in a riot.

LIMITATIONS AND EXCLUSIONS
(Continued)

- (26) scaling and root planing, or other periodontal treatment; unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish Dental Necessity for treatment.
- (27) more than one detailed or extensive oral evaluation per Dentist for you or your Dependent while covered by the Policy or any replacement policy.

COORDINATION OF DENTAL EXPENSE BENEFITS

EFFECT ON BENEFITS. If you or your Dependent is covered by another Plan, the Dental Expense Benefits under the Policy and benefits under the other Plan(s) will be coordinated for the Claim Period. The Order of Benefit Determination Rules on the next page decide which Plan pays first.

- (1) **Primary Benefits.** When this Plan must pay its full benefits first, the Dental Expense Benefits under this Certificate will be paid as if the other coverage did not exist.
- (2) **Secondary Benefits.** When another Plan must pay its full benefits first, the Dental Expense Benefits under this Certificate:
 - (a) will be calculated as if the other coverage did not exist; and then
 - (b) will be reduced so that total benefits, from all Plans combined, will not exceed 100% of the Allowable Expenses incurred by the Claimant during that Claim Period.

Benefits will be coordinated with any benefit amounts that would be payable for the Allowable Expenses under the other Plan(s), whether or not claim is actually made. When this Plan's benefits are reduced, each benefit is reduced in proportion. Then, the reduced benefit payments are applied towards the Maximums of this Plan.

BENEFIT SAVINGS. The amount by which this Plan's benefits have been reduced due to such coordination will accrue during the Claim Period. This amount will be used to pay any Allowable Expenses which:

- (1) are incurred by that Claimant during the same Claim Period; and
- (2) are not otherwise paid by any Plan.

DEFINITIONS. The following definitions apply only to this coordination provision.

"**Plan**" means any group insurance or group type coverages (whether insured or uninsured), which provide medical or dental care benefits or services. This includes but is not limited to:

- (1) Blue Cross and Blue Shield plans;
- (2) blanket (other than school accident coverage) and franchise insurance plans;
- (3) Health Maintenance Organization (HMO) and Dental Maintenance Organization (DMO) plans; and
- (4) other prepayment, group practice and individual practice plans.

It also includes any coverage under a government medical or dental plan required or provided by law; except Medicaid. This Plan must pay its benefits before Medicaid pays. Coordination with Medicare will be in accord with federal law.

Each of the above coverages is a separate Plan. If an arrangement has two or more parts, and its coordination provision applies only to some benefits or services; then each part is a separate plan.

"**Allowable Expense**" means any necessary, Usual and Customary expense for dental care, which is at least partly covered under at least one of the Plans covering the Claimant. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered during the Claim Period will be considered Allowable Expense.

"**Claimant**" means you or your Dependent for whom claim is made.

"**Claim Period**" means a calendar year (or part of a calendar year) during which the Claimant has been covered under the Policy.

DENTAL COVERAGE CONTINUATION

The following provisions comply with the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. These provisions apply when Dental Coverage is provided by a private Employer with 20 or more employees (as defined by COBRA). Any further changes made to the COBRA continuation requirements will automatically apply to these continuation provisions.

RIGHT TO CONTINUE. Insurance may be continued in accord with the following provisions when:

- (1) a Covered Person becomes ineligible for Policy coverage due to a Qualifying Event shown below; and
- (2) the Policy remains in force.

"Qualifying Event," as it applies to you, means your termination of employment, hours reduction or retirement, if it would otherwise result in a Qualified COBRA Beneficiary's loss of Policy coverage.

"Qualifying Event," as it applies to your Covered Dependent, means one of the following events, if it would otherwise result in a Qualified COBRA Beneficiary's loss of Policy coverage:

- (1) your termination of employment, retirement or hours reduction;
- (2) your death, divorce or legal separation;
- (3) your becoming entitled to Medicare benefits; or
- (4) your child's ceasing to be an eligible Covered Dependent, under the terms of the Policy.

"Qualified Beneficiary" means you and your Covered Dependent who is entitled to continue insurance under the Policy, from the date of your first Qualifying Event. It also includes your natural child, legally adopted child or child placed for the purpose of adoption; when the new child:

- (1) is acquired during your 18- or 29-month continuation period; and
- (2) is enrolled for insurance in accord with the terms of the Policy.

But it does **not** include your new spouse, stepchild or foster child acquired during that continuation period; whether or not the new Dependent is enrolled for Policy coverage.

CONTINUATION PERIODS. The maximum period of continued coverage for each Qualifying Event shall be as follows.

Termination of Employment. When eligibility ends due to your termination of employment; then coverage for you and your Covered Dependents may be continued for up to 18 months, from the date employment ended. Termination of employment includes a reduction in hours or retirement. **Exceptions:**

- (1) **Misconduct.** If your termination of employment is for gross misconduct, coverage may **not** be continued for you or your Covered Dependents.
- (2) **Disability.** "Disability" or "Disabled" as used in this section, shall be as defined by Title II or XVI of the Social Security Act and determined by the Social Security Administration.

If you:

- (a) become disabled by the 60th day after your employment ends; and
 - (b) are covered for Social Security Disability Income benefits;
- then coverage for you and your Covered Dependents may be continued for up to 29 months, from the date your employment ended.

If your Dependent:

- (a) becomes disabled by the 60th day after your employment ends; and
 - (b) is covered for Social Security Disability Income benefits;
- then coverage for you and any Covered Dependents may be continued for up to 29 months, from the date your employment ended.

You must send the Company a copy of the Social Security Administration's notice of disability status:

- (a) within 60 days after they find that you are disabled, and before the 18-month continuation period expires; and again
- (b) within 30 days after they find that you are no longer disabled.

(3) **Subsequent Qualifying Event.** If your Dependent:

- (a) is a Qualified Beneficiary; and
- (b) has a subsequent Qualifying Event during the 18- or 29-month continuation period;

then coverage for that Covered Dependent may be continued for up to 36 months, from the date your employment ended.

Loss of Dependent Eligibility. If your Covered Dependent's eligibility ends, due to a Qualifying Event **other than** your termination of employment; then that Dependent's coverage may be continued for up to 36 months, from the date of the event. Such events may include:

- (1) your death, divorce, legal separation, or Medicare entitlement; and
- (2) your child's reaching the age limit, getting married or ceasing to be a full-time student.

One or more subsequent Qualifying Events may occur during your Covered Dependent's 36-month period of continued coverage; but coverage may not be continued beyond 36 months, from the date of the first Qualifying Event.

Medicare Entitlement. If your eligibility under the Policy ends due to a Qualifying Event and you become entitled to Medicare after electing COBRA continuation coverage, then your coverage may not be continued. Coverage may be continued for your Covered Dependents for up to 36 months from date of the first Qualifying Event.

If your eligibility under the Policy continues beyond Medicare entitlement, but later ends due to a Qualifying Event; then your Covered Dependents may continue coverage for up to:

- (1) 36 months from your Medicare entitlement date; or
- (2) 18 months from the date of the first Qualifying Event (whichever is later).

Coverage may not be continued beyond 36 months, from the date of the first Qualifying Event.

NOTICE REQUIREMENTS. The Group Policyholder is required by law to notify the Company within 30 days after the following Qualifying Events:

- (1) your termination of employment, hours reduction or retirement; and
- (2) your death or becoming entitled to Medicare benefits.

You (or other Qualified Beneficiary):

- (1) must notify the Group Policyholder within 60 days after the later of:
 - (a) the date of a divorce; a legal separation; or a child's ceasing to be an eligible Dependent, as defined by the Policy; or
 - (b) the date the coverage would end as a result of one of these events; and
- (2) must notify the Company within 60 days of the Social Security Administration's finding that you or your Dependent became disabled within 60 days after your termination of employment.

ELECTION. To continue Dental Insurance, you must notify the Group Policyholder of such election within 60 days from the latest of:

- (1) the date of the Qualifying Event;
- (2) the date coverage would otherwise end due to the Qualifying Event; or
- (3) the date the Group Policyholder sends notice of the right to continue.

Payment for the cost of the insurance for the period prior to the election must be made to the Group Policyholder, within 45 days after the date of such election. Subsequent payments are to be made to the Group Policyholder, in the manner described by the Group Policyholder. The Group Policyholder will remit all payments to the Company.

TERMINATION. Continued coverage will end at the earliest of the following dates:

- (1) the end of the maximum period of continued coverage shown above;
- (2) the date the Policy or the Employer's participation under the Policy terminates;
- (3) the last day of the period of coverage for which premium has been paid, if any premium is not paid when due;
- (4) the date on which:
 - (a) you again become covered under the Policy;
 - (b) you become entitled (covered) for benefits under Medicare; or
 - (c) you become covered under any other group dental plan, as an employee or otherwise.

OTHER CONTINUATION PROVISIONS. If any other continuation privilege is available to you under the Policy, it will apply as follows.

- (1) **FMLA.** If you continue coverage during leave subject to the Family and Medical Leave Act (FMLA); then COBRA continuation may be elected from the day after the FMLA continuation period ends.
- (2) **Other.** If you continue coverage under any other continuation privilege under the Policy; then that continuation period will run concurrently with any COBRA continuation period provided above.

Another continuation privilege may provide a shorter continuation period, for which the Employer pays all or part of the premium. In that event, your share of the premium may increase for the rest of the COBRA continuation period provided above.

CONTINUITY OF COVERAGE

ELIGIBILITY. You or your Dependent is eligible for credit upon transfer from another employer's group dental plan if the Schedule of Benefits shows that the Continuity of Coverage provision applies and:

- (1) you:
 - (a) are covered under a previous employer's group dental plan within 31 days before Dental Expense Benefits under the Policy take effect for you and coverage with the group dental plan terminates; and
 - (b) immediately become covered under this dental plan on the earliest day that the Dental Expense Benefits under the Policy can take effect.
- (2) your Dependent:
 - (a) is covered under an employer's group dental plan within 31 days before Dental Expense Benefits under the Policy takes effect and coverage with the group dental plan terminates;
 - (b) immediately becomes covered under this dental plan on the earliest day that the Dental Expense Benefits under the Policy can take effect; and
 - (c) you are covered for Group Dental Expense Benefits under the Policy.

EFFECT OF CONTINUITY OF COVERAGE ON BENEFITS. If this provision applies, then your or your Dependent's Dental Expense Benefits will be payable as follows.

- (1) Any amounts used to satisfy that person's Deductible under the prior plan will be credited toward the satisfaction of his or her Deductible under the Policy; provided:
 - (a) the expenses would be Covered Expenses under the Policy;
 - (b) the expenses are incurred during the same [Calendar/Policy/Plan] Year in which Dental Expense Benefits under the Policy take effect; and
 - (c) you send the Company a claim worksheet explaining the benefits paid by the prior plan.
- [2) Orthodontia Benefits paid by the prior plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under the Policy.]
- (3) That person's continuous months of coverage under the prior plan just before it terminated will count toward the Policy's Benefit Waiting Period for Type 2 Procedures (Basic Care) [or Type 3 services (Major Care)], if any.
- [(4) That person's continuous months of coverage under the prior plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under the Policy; but only if both the prior group dental plan and the Policy provide orthodontia benefits.]
- [(5) Expense that person incurs for initial placement of a prosthetic appliance or fixed bridge will be covered; provided:
 - (a) the placement is needed to replace one or more natural teeth extracted while insured for Dental Expense Benefits under the Policy or under the prior group dental plan;
 - (b) the replacement would have been covered under the prior plan; and
 - (c) the extracted teeth are not third molars (wisdom teeth).]

PRIOR PLAN CREDIT

ELIGIBILITY. A Covered Person is eligible for Prior Plan Credit if:

- (1) the Schedule of Benefits shows that the Prior Plan Credit provision applies;
- (2) the Covered Person is covered under:
 - (a) your Employer's prior group dental plan; or
 - (b) the prior dental plan of an affiliate or an entity acquired by your Employer after the Policy's effective date;
on the day before Dental Expense Benefits under the Policy take effect for the Employer, affiliate, or acquired company; and
- (3) the Covered Person immediately becomes covered under this dental plan on the day the Employer's, affiliate's, or acquired company's Dental Expense Benefits under the Policy take effect.

EFFECT OF PRIOR PLAN CREDIT ON BENEFITS. If this provision applies, then your or your Dependent's Dental Expense Benefits will be payable as follows.

- (1) Any amounts used to satisfy that person's Deductible under the prior plan will be credited toward the satisfaction of his or her Deductible under the Policy; provided:
 - (a) the expenses would be Covered Expenses under the Policy;
 - (b) the expenses are incurred during the same [Calendar/Policy/Plan] Year in which Dental Expense Benefits under the Policy take effect; and
 - (c) you send the Company a claim worksheet explaining the benefits paid by the prior plan.
- [2] Orthodontia Benefits paid by the prior plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under the Policy.]
- (3) That person's continuous months of coverage under the prior plan just before it terminated will count toward the Policy's Benefit Waiting Period for Type 2 Procedures (Basic Care) [or Type 3 services (Major Care)], if any.
- [(4) Your or your Dependent child's continuous months of coverage under the prior plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under the Policy; but only if both the prior plan and the Policy provide orthodontia benefits.]
- [(5) Expense that person incurs for initial placement of a prosthetic appliance or fixed bridge will be covered; provided:
 - (a) the placement is needed to replace one or more natural teeth extracted while insured for Dental Expense Benefits under this Policy or under the prior plan;
 - (b) the replacement would have been covered under the prior plan; and
 - (c) the extracted teeth are not third molars (wisdom teeth).]

**LIST OF COVERED DENTAL PROCEDURES
TYPE 1 PROCEDURES - DIAGNOSTIC & PREVENTIVE SERVICES**

- **ROUTINE ORAL EXAMINATIONS**
 - * up to two per calendar year
 - * includes comprehensive evaluation, no more than one per Dentist in 3 years
- **DENTAL X-RAYS**
 - * x-rays taken for orthodontia are not covered under this provision
 - **Bitewing films**
 - * up to four per calendar year, including any bitewings taken as part of a full mouth series
 - * includes any vertical bitewings
 - **Panoramic x-rays; or**
 - **Full mouth x-rays, with periapical x-rays and bitewings**
 - * one complete full mouth series or panoramic film, no more than once every five years
 - **Other dental x-rays**
 - * maximum of six per calendar year
- **PROPHYLAXIS (Routine Cleanings)**
 - * up to two per calendar year[, but this will be reduced by the number of periodontal maintenance cleanings that are paid in the same calendar year]
 - * [one additional routine cleaning per calendar year for Covered Persons who:
 - * are pregnant;
 - * have diabetes; or
 - * have a documented history of heart disease or strokeA doctor's statement confirming the diagnosis and the need for a more frequent cleaning must be submitted to the Company.]
 - * includes polishing of teeth and removal of plaque, calculus and stains
- **PERIODONTAL MAINTENANCE CLEANING**
 - * up to four per calendar year[, but this will be reduced by the number of routine cleanings, including routine cleanings performed for Covered Persons who are pregnant, have diabetes, or have a documented history of health disease or stroke, that are paid in the same calendar year]
 - * following active periodontal therapy
 - * not covered if performed less than 3 months following periodontal surgery
- **FLUORIDE TREATMENTS**
 - * one treatment per calendar year
 - * [for Dependent children through age 15]
 - * [for Covered Persons age 16 or older]
 - * includes fluoride varnish for high-risk patients
 - * does not include take-home or over-the-counter treatments
- **SPACE MAINTAINERS (Passive Appliance)**
 - * one appliance per site while covered under this provision
 - * for Dependent children through age 15
 - * for the purpose of maintaining spaces created by the premature loss of primary teeth
 - * includes all adjustments within six months after installation
 - * does not include repairs or replacement costs
- **SEALANTS**
 - * one treatment per tooth, no more than once in any 36-month period
 - * for Dependent children through age 15
 - * for the occlusal surface of unrestored and non-decayed first and second permanent molars only

LIST OF COVERED DENTAL PROCEDURES
TYPE 1 PROCEDURES - DIAGNOSTIC & PREVENTIVE SERVICES
(continued)

- **APPLIANCE TO INHIBIT THUMB SUCKING AND OTHER HARMFUL HABITS**
 - * one appliance while covered under the Policy
 - * for Dependent children through age 15
 - * includes all adjustments within six months after installation
 - * does not include repairs or replacement costs
- **OTHER SERVICES**
 - * each service is covered one time while covered under the Policy
 - * genetic test for susceptibility to oral diseases
 - * caries susceptibility test
 - * pulp vitality test per tooth

NOTE: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES - BASIC SERVICES**

- **SEALANTS**
 - * one treatment per tooth, no more than once in any 36-month period
 - * for Dependent children through age 15
 - * for the occlusal surface of unrestored and non-decayed first and second permanent molars only
- **EXAMINATIONS**
 - **Oral examinations**, problem-focused and/or emergency exams (other than routine periodic exams)
 - * up to 4 per calendar year
 - * Benefits are payable for an emergency examination or for emergency palliative treatment, but not both in the same visit
- **CONSULTATIONS**
 - * provided by a Dentist other than the Dentist providing any treatment
 - * payable if no other services are rendered
- **EMERGENCY TREATMENT**
 - **Emergency palliative treatment**
 - * Palliative treatment is limited to:
 - * opening and drainage of a tooth when no endodontics is to follow
 - * opening and medicating
 - * smoothing down a chipped tooth
 - * dry socket treatment
 - * pericoronitis treatment
 - * treatment for aphthous ulcers
 - Benefits are payable only if services are rendered in order to relieve dental pain or dental injury
- **INJECTION OF ANTIBIOTICS**
 - * by the Dentist, in the Dentist's office
- **FILLINGS**
 - **Filling**[, includes composite fillings]
 - * [benefits for composite fillings of posterior teeth will be limited to the amount payable for an equivalent amalgam filling]
 - * multiple restorations on the same tooth will be treated as one restoration with multiple surfaces; and multiple restorations on one surface or adjacent surfaces will be treated as one restoration
 - * replacement fillings for a tooth or tooth surface which was filled within the last 12 months are not covered
 - **Pin retention, in addition to restoration**
- **SEDATIVE FILLINGS**
 - * to relieve pain
 - * not covered if used as a base or liner under a restoration
- **PREFABRICATED STAINLESS STEEL OR RESIN CROWNS**
 - * resin crowns are covered for anterior and bicuspid teeth only
 - * replacement for a crown which was placed within the last 24 months is not covered

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES - BASIC SERVICES
(Continued)**

- **EXTRACTIONS AND ORAL SURGERY**
 - * includes local anesthesia and routine post operative visits
 - * extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
 - * extractions and surgical exposure of teeth, when related to orthodontic treatment, are not covered under this provision
- **Simple extraction**
- **Surgical removal of erupted tooth**
- **Removal of impacted tooth** (soft tissue, partially or completely bony)
- **Surgical exposure of impacted or unerupted tooth**, to aid eruption
- **EXTRACTIONS AND ORAL SURGERY**
 - * includes local anesthesia and routine post operative visits
 - * extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
 - * extractions and surgical exposure of teeth, when related to orthodontic treatment, are not covered under this provision
- **Simple extraction**
- **Surgical removal of erupted tooth**
- **Removal of impacted tooth** (soft tissue, partially or completely bony)
- **Surgical exposure of impacted or unerupted tooth**, to aid eruption
- **Excision of hyperplastic tissue**
- **Excision of pericoronal gingiva**
- **Removal of exposed roots**
- **Surgical removal of residual tooth roots**
- **Excision of lesions, malignant or benign tumors**
- **Radical resection of bone for tumor with bone graft**
- **Incision and removal of foreign body from soft tissue**
- **Removal of foreign body from bone**
- **Maxillary sinusotomy for removal of tooth fragment or foreign body**
- **Suture of soft tissue wound**
 - * excludes closure of surgical incisions
- **Incision and drainage of abscess**
- **Frenulectomy**
- **Sialolithotomy and Sialodochoplasty**
- **Dilation of salivary duct**
- **Sequestrectomy for osteomyelitis or bone abscess**
- **Closure of fistula, salivary or oroantral**
- **Reimplantation of tooth or tooth bud due to an accident**
- **Alveolectomy** (with or without extractions)
- **Vestibuloplasty**
- **Removal of exostosis of the maxilla or mandible**
 - * includes removal of tori
- **Biopsy and examination of oral tissue**
 - * includes brush biopsy [and FDA-approved oral cancer screening system]

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES - BASIC SERVICES
(Continued)**

- **ADMINISTRATION OF ANESTHESIA**
 - **General anesthesia or I.V. sedation**
 - * administered in the Dentist's office by the Dentist or other person licensed to administer anesthesia
 - * payable in connection with:
 - * a complex cutting procedure;
 - * a documented health history that would require the administration of anesthesia;
 - * a child through 6 years of age; or
 - * a physically or developmentally disabled Covered Person
 - * not covered when benefits for the accompanying surgical procedure are not payable
 - * not covered when administered due to patient anxiety
 - * anesthesia, when related to orthodontic treatment, is not covered under this provision
- **REPAIR of PROSTHETICS**
 - * no benefits are payable within six months of installation
 - **Repair of dentures**
 - * repair of complete denture includes repair of broken base and replacement of missing or broken teeth
 - * repair of partial dentures includes repair of acrylic saddles on base, cast framework, repair or replacement of broken clasp, and replacement of missing or broken teeth
 - **Repair or recementation of inlays, crowns and bridges**
- **OCCLUSAL GUARD**
 - * one in any 24-month period
- **ENDODONTICS** (treatment of diseases of root canal, periapical tissue and pulp chamber)
 - **Pulp cap**, direct or indirect
 - * not covered if done on the same day as the permanent restoration
 - **Pulpotomy**
 - * primary teeth only
 - **Gross pulpal debridement**
 - **Root canal therapy**
 - * permanent teeth only
 - * includes necessary x-rays and cultures
 - * retreatment not covered for 12 months
 - **Root canal obstruction: non-surgical treatment**
 - **Incomplete endodontic therapy, inoperable or fractured tooth**
 - **Internal root repair of perforation defects**
 - **Apexification**
 - **Apicoectomy**
 - **Root amputation**
 - **Hemisection**

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES - BASIC SERVICES
(Continued)**

- **PERIODONTICS** (treatment of disease of the soft tissue or bone surrounding the tooth)
- **PERIODONTAL SURGERY**
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
 - * surgical treatment includes post operative visits
 - * one operative session per site in any 36-month period
 - * benefits for multiple periodontal surgeries within the same quadrant on the same day will be paid based on the most comprehensive procedure provided that day
- **Gingivectomy or gingivoplasty**
- **Osseous surgery**
- **Soft tissue graft**
- **Bone replacement graft**
- **Subepithelial connective tissue graft**
- **Guided tissue regeneration**
 - * not covered under this provision if performed in a site where the tooth has been extracted
- **Crown lengthening**
- **NON-SURGICAL PERIODONTAL SERVICES**
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
 - * benefit payment may be based on tooth, sextant or quadrant
- **Full-Mouth Debridement**
 - * one treatment in any 24-month period
- **Scaling and root planing**, for pathological alveolar bone loss
 - * one treatment in any 24-month period
 - * not covered if performed less than 3 months following periodontal surgery
- **Localized delivery of chemotherapeutic agent by means of a controlled release vehicle**
 - * following active periodontal therapy which has failed to resolve the condition
 - * one per tooth in any 36-month period
- **PERIODONTAL MAINTENANCE CLEANING**
 - * up to four per calendar year[, but this will be reduced by the number of routine cleanings, including routine cleanings performed for Covered Persons who are pregnant, have diabetes, or have a documented history of health disease or stroke, that are paid in the same calendar year]
 - * following active periodontal therapy
 - * not covered if performed less than 3 months following periodontal surgery
- **OCCLUSAL ADJUSTMENT**
 - * maximum of one adjustment per quadrant in any 36-month period

NOTE: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES - MAJOR SERVICES**

- **ENDODONTICS** (treatment of diseases of root canal, periapical tissue and pulp chamber)
 - **Pulp cap**, direct or indirect
 - * not covered if done on the same day as the permanent restoration
 - **Pulpotomy**
 - * primary teeth only
 - **Gross pulpal debridement**
 - **Root canal therapy**
 - * permanent teeth only
 - * includes necessary x-rays and cultures
 - * retreatment not covered for 12 months
 - **Root canal obstruction: non-surgical treatment**
 - **Incomplete endodontic therapy, inoperable or fractured tooth**
 - **Internal root repair of perforation defects**
 - **Apexification**
 - **Apicoectomy**
 - **Root amputation**
 - **Hemisection**
- **PERIODONTICS** (treatment of disease of the soft tissue or bone surrounding the tooth)
- **PERIODONTAL SURGERY**
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
 - * surgical treatment includes post operative visits
 - * one operative session per site in any 36-month period
 - * benefits for multiple periodontal surgeries within the same quadrant on the same day will be paid based on the most comprehensive procedure provided that day
 - **Gingivectomy or gingivoplasty**
 - **Osseous surgery**
 - **Soft tissue graft**
 - **Bone replacement graft**
 - **Subepithelial connective tissue graft**
 - **Guided tissue regeneration**
 - * not covered under this provision if performed in a site where the tooth has been extracted
 - **Crown lengthening**
- **NON-SURGICAL PERIODONTAL SERVICES**
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
 - * benefit payment may be based on tooth, sextant or quadrant
 - **Full-Mouth Debridement**
 - * one treatment in any 24-month period
 - **Scaling and root planing**, for pathological alveolar bone loss
 - * one treatment in any 24-month period
 - * not covered if performed less than 3 months following periodontal surgery
 - **Localized delivery of chemotherapeutic agent by means of a controlled release vehicle**
 - * following active periodontal therapy which has failed to resolve the condition
 - * one per tooth in any 36-month period
- **PERIODONTAL MAINTENANCE CLEANING**
 - * up to four per calendar year[, but this will be reduced by the number of routine cleanings, including routine cleanings performed for Covered Persons who are pregnant, have diabetes, or have a documented history of health disease or stroke, that are paid in the same calendar year]
 - * following active periodontal therapy
 - * not covered if performed less than 3 months following periodontal surgery

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES - MAJOR SERVICES
(Continued)**

- **ORAL SURGERY**
 - * includes local anesthesia and routine post operative visits
 - **Removal of exposed roots**
 - **Surgical removal of residual tooth roots**
 - **Excision of lesions, malignant or benign tumors**
 - **Radical resection of bone for tumor with bone graft**
 - **Incision and removal of foreign body from soft tissue**
 - **Removal of foreign body from bone**
 - **Maxillary sinusotomy for removal of tooth fragment or foreign body**
 - **Suture of soft tissue wound**
 - * excludes closure of surgical incisions
 - **Incision and drainage of abscess**
 - **Frenulectomy**
 - **Sialolithotomy and Sialodochoplasty**
 - **Dilation of salivary duct**
 - **Sequestrectomy for osteomyelitis or bone abscess**
 - **Closure of fistula, salivary or oroantral**
 - **Reimplantation of tooth or tooth bud due to an accident**
 - **Excision of hyperplastic tissue**
 - **Excision of pericoronal gingiva**
 - **Alveolectomy (with or without extractions)**
 - **Vestibuloplasty**
 - **Removal of exostosis of the maxilla or mandible**
 - * includes removal of tori
- **ADMINISTRATION OF ANESTHESIA**
 - **General anesthesia or I.V. sedation**
 - * administered in the Dentist's office by the Dentist or other person licensed to administer anesthesia
 - * payable in connection with:
 - * a complex cutting procedure;
 - * a documented health history that would require the administration of anesthesia;
 - * a child through 6 years of age; or
 - * a physically or developmentally disabled Covered Person
 - * not covered when benefits for the accompanying surgical procedure are not payable
 - * not covered when administered due to patient anxiety
 - * anesthesia, when related to orthodontic treatment, is not covered under this provision

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES - MAJOR SERVICES
(Continued)**

- **PROSTHODONTICS - Fixed or Removable**
Services to replace teeth extracted or accidentally lost [while covered under the Policy]
 - * includes adjustments, within six months of the placement date
 - * benefits are not payable for temporary or provisional services
- **Bridge abutments and pontics (fixed)**
 - * replacement [including/excluding a dental implant] is limited to one time in any 8 consecutive years from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury
- **Dentures, complete (upper or lower) or partial (upper or lower) or unilateral partial (removable)**
 - * fees for partial dentures include all conventional clasps, rests and teeth
 - * includes addition of teeth or clasp(s) to an existing partial denture [to replace natural teeth extracted or accidentally lost while covered under the Policy]
 - * replacement [including/excluding a dental implant] is limited to once in any 5 consecutive years, per denture, from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury, provided the existing denture is not serviceable
- **Adjustments to dentures**, more than six months after installation
- **Tissue conditioning**
 - * one per arch per calendar year
- **Reline of complete or partial denture**
 - * one per calendar year, per denture
- **Rebase of complete or partial denture**
 - * once in any 5-year period, per denture
- **Guided tissue regeneration**, at the site of an extracted tooth
 - * one per site while covered under the Policy
- **Dental implants**
 - * not covered for claimants prior to age 16
 - * implants are limited to one per tooth in any 8 consecutive years; or sooner, if a replacement is required because of an accidental dental injury sustained while the Covered Person is covered under the Policy
- **Surgical placement of implant body**
- **Implant prosthetics**
 - * implant-supported crown
 - * abutment-supported crown
 - * implant abutment (includes placement)
 - * implant-supported retainer
 - * abutment-supported retainer
- **Other implant procedures**
 - * implant maintenance procedures
 - * repair implant abutment
 - * repair implant-supported prosthesis
 - * removal of implant body
- **Bone replacement graft**, at the site of an extracted tooth
 - * one per site while covered under the Policy

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES - MAJOR SERVICES
(Continued)**

- **MAJOR RESTORATIONS**

- * inlays, onlays, veneers, and crowns are covered only when needed due to substantial loss of tooth structure caused by decay or accidental Injury to teeth
- * benefits are not payable for the placement of an inlay, onlay, veneer, or crown within 8 years since the placement date of an inlay, onlay, veneer, or crown on the same tooth, unless replacement is required due to an accidental Injury
- * benefits are not payable for temporary or provisional services
- * temporary services in place for one year or more are considered to be permanent services and are subject to the Policy's frequency limitations
- * not covered for claimants prior to age 16

- **Inlays**
- **Onlays**
- **Crowns and posts**
- **Crown build-up**, in conjunction with a payable crown
- **Cast post and core**, in conjunction with a payable crown
- **Cast post**, as part of a payable crown
- **Veneers**

- **TREATMENT OF DISORDERS OF THE TEMPOROMANDIBULAR JOINT**

- **includes anesthesia and postoperative care**
- **reduction of dislocation, open or closed**
- **manipulation under general anesthesia**
- **condylectomy**
- **excision or repair of disc**
- **synovectomy**
- **myotomy**
- **joint reconstruction**
- **arthrotomy**
- **arthroplasty**
- **arthrocentesis**
- **arthroscopy**
- **orthodontic appliances**
- **occlusal orthotic devices**

NOTE: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 4 PROCEDURES - ORTHODONTICS
(FOR DEPENDENT CHILDREN)**

- **ORTHODONTICS**

Active and passive services related to the guidance and alignment of teeth

- **Diagnostic services**
 - * **Examinations**
 - * **X-rays**
 - * **Diagnostic casts or study models**
- **Treatment plan**
- **Orthodontic extractions**
 - * includes anesthesia, if Necessary
- **Transseptal Fibrotomy**
- **Orthodontic appliances**

**LIST OF COVERED DENTAL PROCEDURES
TYPE 1 - DIAGNOSTIC & PREVENTIVE SERVICES**

STANDARD SCHEDULED BENEFIT PLAN

		Maximum Benefit
DIAGNOSTIC SERVICES		
ORAL EXAMINATIONS		
<ul style="list-style-type: none"> up to two per calendar year 		
	Periodic	\$25
	Comprehensive	\$37
DENTAL X-RAYS		
<ul style="list-style-type: none"> x-rays taken for orthodontia are not covered under this provision of the Policy 		
Bitewing films		
<ul style="list-style-type: none"> up to four per calendar year, including any bitewings taken as part of a full mouth or panoramic series 		
	2 films	\$21
	4 films	\$32
Panoramic x-rays; or Full mouth series, with periapical x-rays and bitewings		
<ul style="list-style-type: none"> one complete full mouth or panoramic series in any five consecutive years 		
	Panoramic film	\$59
	Intraoral-Complete Including Bitewings	\$71
Other dental x-rays, needed to diagnose a specific dental condition		
<ul style="list-style-type: none"> maximum of 6 per calendar year 		
	Periapical-first film	\$13
	Periapical-each additional film	\$10
	Intraoral-occlusal film	\$18
	Extraoral-first film	\$22
PREVENTIVE CARE		
PROPHYLAXIS (Routine Cleanings)		
<ul style="list-style-type: none"> up to two per calendar year includes polishing of teeth and removal of plaque, calculus and stains 		
	Age 16 and older	\$52
	Through age 15	\$31
FLUORIDE TREATMENTS		
<ul style="list-style-type: none"> one treatment per calendar year for Dependent children through age 15 		
	Including prophylaxis	\$48
	Not including prophylaxis	\$20

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 1 – DIAGNOSTIC & PREVENTIVE SERVICES
(Continued)**

Maximum Benefit

SPACE MAINTAINERS (Passive Appliance)

- for Dependent children through age 15
- for the purpose of maintaining spaces created by the premature loss of primary teeth
- includes all adjustments within six months after installation

Fixed–unilateral	\$179
Fixed–bilateral	\$277

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

LIST OF COVERED DENTAL PROCEDURES TYPE 2 - BASIC SERVICES

STANDARD SCHEDULED BENEFIT PLAN

MAXIMUM BENEFIT

SEALANTS

- for Dependent children through age 15
- for the occlusal surface of unrestored and non-decayed first and second permanent molars only
- one treatment per tooth in any 36 consecutive months

Per tooth	\$23
-----------	------

BASIC RESTORATIONS

Fillings:

- benefits for composite fillings of posterior teeth will be limited to the amount payable for an equivalent amalgam filling
- multiple restorations on the same tooth will be treated as one restoration with multiple surfaces; and multiple restorations on one surface or adjacent surfaces will be treated as one restoration
- replacement fillings for a tooth or tooth surface which was filled within the last six months are not covered
- includes pin retention, in addition to restoration

Amalgam-1 surface primary tooth	\$46
Amalgam-2 surfaces primary tooth	\$57
Amalgam-3 surfaces primary tooth	\$69
Amalgam-1 surface permanent tooth	\$53
Amalgam-2 surfaces permanent tooth	\$66
Amalgam-3 surfaces permanent tooth	\$79
Composite-1 surface anterior tooth	\$61
Composite-2 surfaces anterior tooth	\$77
Composite-3 surfaces anterior tooth	\$94

Prefabricated stainless steel or resin crowns

- for covered Dependent children through age 15
- one per tooth, in any 5 consecutive years

Stainless steel crown-primary tooth	\$112
Stainless steel crown-permanent tooth	\$120
Resin crown	\$122
Stainless steel crown with resin	\$141

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 - BASIC SERVICES
(Continued)**

MAXIMUM BENEFIT

ORAL SURGERY

- oral surgery includes local anesthesia and routine post operative visits
- extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
- where related to orthodontic treatment, extractions and surgical exposure of teeth are not covered under this provision

Simple extraction

Single tooth	\$58
Each additional tooth	\$54

Surgical removal of erupted tooth

With mucoperiosteal flap	\$107
--------------------------	-------

Removal of impacted tooth

Soft tissue impaction	\$136
Partially bony impacted	\$177
Completely bony impacted	\$208

Surgical exposure of tooth, to aid eruption

Exposure of impacted or unerupted tooth	\$166
-----------------------------------------	-------

Excision of hyperplastic tissue

Per arch	\$204
----------	-------

Excision of pericoronal gingiva

	\$80
--	------

Removal of exposed roots

Root Removal	\$73
--------------	------

Surgical removal of residual tooth roots

Surgical removal	\$114
------------------	-------

Excision of lesions, malignant or benign tumors

Radical excision-up to 1.25 cm diameter	\$229
Benign tumor-up to 1.25 cm diameter	\$184

Incision and removal of foreign body from soft tissue

Remove foreign body	\$100
---------------------	-------

Removal of foreign body from bone

Remove foreign body	\$186
---------------------	-------

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 - BASIC SERVICES
(Continued)**

	MAXIMUM BENEFIT
ORAL SURGERY (continued)	
Maxillary sinusotomy for removal of tooth fragment or foreign body	
Remove tooth fragment or foreign body	\$704
Suture of soft tissue wound	
▪ excludes closure of surgical incisions	
Recent wounds, up to 5 cm	\$78
Incision and drainage of abscess	
Intraoral soft tissue	\$70
Frenulectomy	
Frenulectomy or frenulotomy	\$159
Sialolithotomy / Sialodochoplasty	
Sialolithotomy	\$305
Sequestrectomy for osteomyelitis or bone abscess	
Sequestrectomy	\$146
Closure of fistula	
Salivary	\$554
Oral antral	\$601
Reimplantation	
Tooth or tooth bud	\$196
EMERGENCY TREATMENT	
Emergency examination and palliative treatment	
Palliative treatment is limited to:	
▪ opening and drainage of a tooth when no endodontics is to follow	
▪ smoothing down a chipped tooth	
▪ dry socket treatment	
▪ pericoronitis treatment	
▪ treatment for aphthous ulcers	
Benefits for emergency treatment are payable only if services are rendered in order to relieve dental pain or dental injury	
Emergency palliative treatment	\$40
CONSULTATIONS	
▪ provided by a Dentist other than the Dentist providing any treatment	
▪ payable if no other services are rendered	
Consultation-diagnostic services only	\$47

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 - BASIC SERVICES
(Continued)**

MAXIMUM BENEFIT

ADMINISTRATION OF ANESTHESIA

General anesthesia or I.V. sedation

- administered in the Dentist's office by the Dentist or other person licensed to administer anesthesia
- payable in connection with a Necessary complex oral surgery procedure
- payable when underlying medical condition, age or health factors render anesthesia medically necessary
- not covered when benefits for the accompanying surgical procedure are not payable
- not covered when administered due to patient anxiety
- anesthesia for orthodontic procedures (or for procedures to treat craniomandibular or temporomandibular joint disorders, where required by state law) is not covered under this provision of this Policy

General Anesthesia-First 30 Minutes	\$169
Each Additional 15 Minutes	\$60
IV Sedation	\$177

PATHOLOGY

Biopsy and examination of oral tissue

Histopathology exam	\$65
Biopsy of oral soft tissue	\$114

REPAIR OF PROSTHETICS

- no benefits are payable within six months of installation if the repair is provided by the same Dentist who installed the prosthetic

Repair of dentures

Broken Complete Denture Base	\$63
Complete Denture-Missing/Broken Tooth	\$53
Repair Resin Denture Base	\$62
Repair Cast Framework	\$75
Repair/Replace Broken Clasp	\$80
Replace Broken Tooth-Per Tooth	\$55
Re-cement Fixed Partial Denture	\$53
Repair of Fixed Partial Denture	\$113

Repair or re-cementation of inlays, crowns and bridges

Re-cement Space Maintainer	\$30
Re-cement Inlay	\$39
Re-cement Crown	\$38

OTHER BASIC SERVICES

Injection of antibiotics

- by the Dentist, in the Dentist's office

Injection	\$28
-----------	------

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES**

STANDARD SCHEDULED BENEFIT PLAN

MAXIMUM BENEFIT

ENDODONTICS (treatment of diseases of root canal, periapical tissue and pulp chamber)

Pulp Cap – Direct

- does not include final restoration
- indirect pulp cap not covered

Pulp Cap–Direct	\$15
-----------------	------

Pulpotomy

- primary teeth only

Therapeutic Pulpotomy	\$38
-----------------------	------

Root canal therapy

- permanent teeth only
- includes necessary x-rays and cultures

Anterior tooth, excluding final restoration	\$163
Bicuspid, excluding final restoration	\$196
Molar, excluding final restoration	\$254
Retreatment of previous root canal, more than one year after initial treatment	
-Anterior tooth	\$221
-Bicuspid	\$255
-Molar	\$300

Apexification

Apexification/recalcification-initial visit	\$70
---------------------------------------------	------

Apicoectomy

Apicoectomy/periradicular surgery	
• Anterior tooth	\$182
• Bicuspid-1 root	\$202
• Molar-1 root	\$219
• Each additional root	\$76

Root amputation

Retrograde Filling-Per Root	\$49
Root Amputation–Per Root	\$109

Hemisection

Includes Root Removal; without Root Canal	\$88
-------------------------------------------	------

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES
(Continued)**

MAXIMUM BENEFIT

PERIODONTICS (treatment of disease of the soft tissue or bone surrounding the tooth)

- periodontal therapy is not covered unless bone and attachment loss is 4 mm or greater, by quadrant; and confirmed by x-rays and pocket depth charting for each tooth
- surgical treatment includes post operative visits
- benefits for multiple periodontal surgeries within the same quadrant on the same day will be paid based on the most comprehensive procedure provided that day

Gingivectomy or gingivoplasty

Per quadrant	\$124
Per tooth	\$39

Osseous or mucogingival surgery

- one per quadrant in each 36 consecutive months

Osseous surgery including flap entry and closure-per quadrant	\$272
---------------------------------------------------------------	-------

Soft tissue graft

Pedicle soft tissue graft	\$200
Free soft tissue graft, including donor site	\$215

Bone replacement graft

First site in quadrant	\$116
Each additional site in quadrant	\$97

Subepithial connective tissue graft

Tissue graft	\$251
--------------	-------

Guided tissue regeneration

Resorbable barrier, per site	\$134
Nonresorbable barrier, per site	\$157

Crown lengthening

Hard tissue-per tooth	\$187
-----------------------	-------

Debridement

- one treatment per quadrant in each 24 consecutive months

Full Mouth Debridement To Enable Evaluation and Diagnosis	\$36
--------------------------------------------------------------	------

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES
(Continued)**

MAXIMUM BENEFIT

Chemotherapeutics, for areas of refractory disease

localized delivery of chemotherapeutic agent by means of a controlled release vehicle

- following active periodontal therapy which has failed to resolve the condition
- does not include irrigation

Chemotherapeutics	\$29
-------------------	------

Provisional Splinting

Intracoronal	\$76
Extracoronal	\$72

MAJOR RESTORATIONS

Crowns and posts

- not covered for claimants prior to age 16
- covered only when needed due to substantial loss of tooth structure caused by decay or accidental injury to teeth, which cannot be repaired by fillings
- replacement of crowns is limited to one time in any eight years

Resin Crown	\$99
Porcelain/Ceramic Substrate	\$294
Porcelain Crown Fused to Predominantly Base Metal	\$249
Porcelain Crown Fused To Noble Metal	\$262
Full Cast Crown-Predominantly Base Metal	\$246
Full Cast Crown with Noble Metal	\$257

- the following services may be covered, subject to Necessity

Core Buildup, Including Pins	\$63
Cast Post & Core In Addition To Crown	\$92
Prefab Post & Core In Addition To Crown	\$80

Inlays and onlays

- Inlays and onlays are covered only when needed due to substantial loss of tooth structure caused by decay or accidental injury to teeth, which cannot be repaired by fillings
- replacement of inlays and onlays is limited to one time in any eight years

Inlay-Metallic-3 or More Surfaces	\$245
Inlay-Porcelain/Ceramic-3 or More Surfaces	\$237
Inlay-Resin Based Composite-3 or More Surfaces	\$209
Onlay-Metallic-3 Surfaces	\$259
Onlay-Porcelain/Ceramic-3 Surfaces	\$261
Onlay-Resin-Based Composite-3 Surfaces	\$244

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES
(Continued)**

MAXIMUM BENEFIT

ORAL SURGERY - ALVEOLAR OR GINGIVAL RECONSTRUCTION

Alveolectomy / Alveoplasty

With extractions-per quadrant	\$53
Without extractions-per quadrant	\$111

Vestibuloplasty

Ridge extension	\$511
-----------------	-------

Removal of exostosis of the maxilla or mandible

- includes removal of tori

Maxilla or Mandible	\$286
---------------------	-------

PROSTHODONTICS - Fixed or Removable

Services to replace teeth extracted or accidentally lost while covered under the Policy

- precision attachments, overdentures, specialized techniques and characterizations are not covered

Bridge abutments and pontics

- replacement is limited to one time in any eight consecutive years

Pontic-Cast Noble Metal	\$258
Pontic-Porcelain Fused To Noble Metal	\$254
Pontic-Resin with Noble Metal	\$259

Dentures

- includes adjustments, within six months of the placement date
- replacement is limited to once in any five consecutive years, per denture, if the denture cannot be made serviceable.
- fees for partial dentures include all conventional clasps, rests and teeth

Complete denture

Complete Denture-Maxilla	\$321
Complete Denture-Mandible	\$316

Partial denture - upper or lower

- acrylic base or predominantly base cast with acrylic saddles

Maxilla Partial Denture-Resin Base	\$241
Mandible Partial Denture-Resin Base	\$288
Maxillary Partial Denture-Cast Metal Frame with Resin	\$360
Mandible Partial Denture-Cast Metal Frame	\$362

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 - MAJOR SERVICES
(Continued)**

MAXIMUM BENEFIT

Removable unilateral partial denture

one piece, predominantly base casting, clasp attachments (including pontics)	\$460
---------------------------------------------------------------------------------	-------

Adjustments to dentures, more than six months after installation

Complete Upper Denture	\$17
Complete Lower Denture	\$17
Partial Upper Denture	\$19
Partial Lower Denture	\$18

Special tissue conditioning

- one per arch per calendar year

Maxillary Tissue Conditioning	\$32
-------------------------------	------

Reline of complete or partial denture

- once in any 36 consecutive months, per denture

Complete Maxillary Denture Chairside	\$68
Complete Mandibular Denture Chairside	\$69

Rebase of complete or partial denture

- once in any five consecutive years, per denture

Complete Upper Denture	\$122
Complete Lower Denture	\$123
Upper Partial Denture	\$120

Addition of teeth or clasp(s) to existing partial denture to replace natural teeth extracted or accidentally lost while covered under the Policy

Tooth To Existing Partial Denture	\$41
Add Clasp To Existing Partial Denture	\$49

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 4 - ORTHODONTICS**

STANDARD SCHEDULED BENEFIT PLAN

ORTHODONTICS

Active and passive services related to the guidance and alignment of teeth

Diagnostic services

Examinations

X-rays

Diagnostic casts or study models

Treatment plan

Orthodontic extractions

- includes anesthesia, if necessary

Orthodontic appliances

MAXIMUM BENEFIT

	\$1,000
SERVICE	
Initial visit, including all diagnostics	\$80
Monthly visits	\$40

Maximum benefit includes benefits paid for orthodontia-related x-rays, extractions and other related services.

Please Note: Benefits are payable for categories of service, shown in Bold. Benefits illustrated for procedures within a category of services are for the most common services. If your dentist recommends a procedure not specifically shown above, you may call Client Services at the number shown on your ID card to determine how the service is covered.

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

<i>SERFF Tracking Number:</i>	<i>JEPT-126218170</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Lincoln National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42849</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Dental</i>		
<i>Project Name/Number:</i>	<i>2009 Dental Rewrite/</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: JEPT-126218170 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42849
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: 2009 Dental Rewrite/

Supporting Document Schedules

Satisfied -Name: Flesch Certification	Review Status: Approved-Closed	07/10/2009
Comments:		
Attachments:		
FL070709 AR Dental Readability.pdf		
FL070709 AR Dental Regulation 19.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	07/10/2009
Comments:		
The GL2-APP.09/02 was approved 05/04/2007.		
Satisfied -Name: Statement of Variability	Review Status: Approved-Closed	07/10/2009
Comments:		
Attachment:		
FL070709 AR Dental Variability.pdf		

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

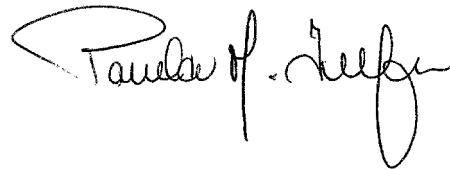
READABILITY CERTIFICATION

This is to certify that the forms shown below have achieved the indicated Flesch Reading Ease Score.

<u>FORM NO.</u>	<u>FLESCH SCORE</u>
GL11-3-SB 07	53.0
GL11-4-DF 09	57.1
GL11-6-ELE 07	52.5
GL11-7-TE 07	51.4
GL11-8-ELD 09 AR	61.6
GL11-9-TD 07	54.8
GL11-10-PR 09	60.0
GL11-11-PT 08	63.7
GL11-12-DB 07	51.4
GL11-13-AP 07	50.2
GL11-14-DBO 07	50.8
GL11-16-EX 09	50.1
GL11-17-COB 07	54.3
GL11-20 07-COBRA	54.2
GL11-CONT 09	62.1
GL11-PIC 07	50.5
GL11-DP.1 07	N/A
GL11-DP.2 07	N/A
GL11-DP.3 07	N/A
GL11-DP.4 07	N/A
GL11-DPSB.1 07	N/A
GL11-DPSB.2 07	N/A
GL11-DPSB.3 07	N/A
GL11-DPSB.4 07	N/A
GL12-3-SB 07	50.6
GL12-4-DF 09	57.7
GL12-6-ELE 07	50.8
GL12-7-TE 07	50.2
GL12-8-ELD 09 AR	61.4
GL12-9-TD 07	51.5
GL12-12-DB 07	52.1
GL12-13-AP 07	50.2
GL12-14-DBO 07	51.1
GL12-16-EX 09	51.4
GL12-17-COB 07	52.7

Readability Certification
(continued)

GL12-20 07-COBRA	54.2
GL12-CONT 09	62.6
GL12-PIC 07	51.0
GL12-DP.1 07	N/A
GL12-DP.2 07	N/A
GL12-DP.3 07	N/A
GL12-DP.4 07	N/A
GL12-DPSB.1 07	N/A
GL12-DPSB.2 07	N/A
GL12-DPSB.3 07	N/A
GL12-DPSB.4 07	N/A



(An Officer of the Company)

Pamela Telfer

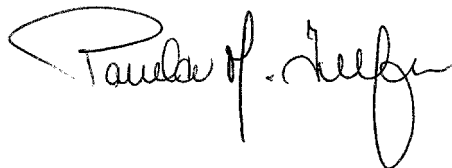
Assistant Vice President – Product Compliance

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: The Lincoln National Life Insurance Company

Form Number(s): GL11-3-SB 07, et al.

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

A handwritten signature in black ink, appearing to read "Pamela M. Telfer", written over a horizontal line.

Signature of Company Officer

Pamela M. Telfer
Name

Assistant Vice President, Product Compliance & State Filing
Title

July 7, 2009
Date

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY
APPENDIX OF VARIABILITY
Supplemental Information on Alternate Versions and Variables for Forms in
Group Dental Policy Series GL11 and Certificate Series GL12

The following forms may be used with the group Dental benefits provided in this Series. Forms numbered GL11 are policy insert pages, while those numbered GL12 are certificate insert pages.

1. **Schedule of Benefits. Form GL11-3-SB 07 and GL12-3-SB 07**

Policy form *GL11-3-SB 07* and certificate form *GL12-3-SB 07* contain the Schedule of Benefits. We request that the section headed "Dental Preferred Provider Organization (PPO)" be filed as variable to omit when not applicable. We request that underlined references to Covered Employees or Employees be variable to accommodate retiree, associate, member, or other language requested by the Policyholder. The underlined web site and contact information are variable to accommodate any future changes to these items. We request variable filing of the Schedule so that the classifications, minimum hours, benefit choices, deductibles, benefit waiting periods, eligibility waiting periods and employer contributions can be as elected by the Policyholder. Benefit waiting periods for basic (Type 2) services will range from 0 to 3 months. Benefit waiting periods for major (Type 3) will range from 0 to 12 months. Benefit waiting periods for orthodontic (Type 4) services will range from 0 to 24 months. The "To Whom Payable" language will be omitted when not applicable.

2. **Definitions. Forms GL11-4-DF 09 and Certificate form GL12-4-DF 09**

Policy Form *GL11-4-DF 09* and certificate Form *GL12-4-DF 09* contain the standard definitions. We request that underlined references to Covered Employees or Employees be variable to accommodate retiree, associate, member, or other language requested by the Policyholder. We also request variable filing of the following bracketed definitions:

Active Work, so that it can be omitted when not applicable, or adapted to atypical worksites and schedules (such as telecommuters, academic years, or union hour banks); so that the exception for non-medical leaves of absence in item (3) may range from 2 weeks to 60 months, or omitted; and so the references to "Military Leave" and "Family Medical Leave" may be omitted for groups that are not subject to those federal requirements.

If the group includes atypical work sites, the Actively at Work definition may include the following item: an alternate work site at the direction of/approved by the Employer.

If the group includes teachers, an item may be added to the days considered Actively at Work to state: a school/academic break or school/academic vacation. An Active Member definition may be included to mean a member of the Group Policyholder who is employed as a teacher with a workload of at least (%) full-time during the teacher contract year. (%= 30-90)

If members are included, Active Member may be included to mean a member in good standing with the Group Policyholder/a member who has accumulated at least # contribution hours in a contribution quarter or Hour Bank/a member who has worked # hours in a work quarter, work period, eligibility quarter, or eligibility period or # hours in a Hour Bank. (#= 20-2080 depending on the accumulation period).

Annual Enrollment Period, so that it can be omitted when not applicable, or so that it can be changed to accommodate retirees, associates, or other language as requested by the Group Policyholder; and so that the 31-day limitation can vary up to 60 days. Benefit Waiting Periods and/or Late Entrant Limitations can be omitted when not applicable.

Benefit Waiting Period, so it can be omitted when not applicable.

Change in Family Status, so additional status changes can be added by group request or it can be omitted when not applicable. References to Section 125 Plans can be changed to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account.

Company, so that the Group Insurance Service Office and address can be updated if necessary.

Coverage Month, so that it may be amended to accommodate group-specific needs.

Covered Employee, so that underlined references to Covered Employees or Employees be variable to accommodate retiree, associate, member, or other language requested by the Policyholder.

Covered Expenses, so that one of the alternate definitions for Covered Expenses can be used, depending on which dental plan is selected. The underlined text can be used when more than one Plan or type of service is provided under a policy. The bracketed text can be removed when that type of service is not elected.

a. Regular Indemnity (Standard Plan – Non PPO):

COVERED EXPENSES, for Plan 1, means expenses which:

- (1) are Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy; and
- (2) do not exceed this Policy's Usual and Customary allowances.

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by this Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of this Policy.

b. PPO Plan:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy. Covered Expenses:

- (1) for a Participating Dentist, do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the fee allowed by the Dentist's contract with the dental network; whichever is less; or
- (2) for a Non-Participating Dentist's charges, do not exceed[:
 - (a)] for Type 1, 2, or 3 procedures, this Policy's Usual and Customary allowances[; and
 - (b) for Type 4 procedures, the maximum Covered Expense, as determined by the Company].

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by this Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of this Policy.

c. Scheduled Indemnity Plan:

COVERED EXPENSES, for Plan 1, means expenses which:

- (1) are Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy; and
- (2) do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the scheduled fee contained in this Policy; whichever is less.

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by this Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of this Policy.

d. PPO Plan with Schedule for Out-of-Network, except U & C for Type 1, 2 or 3:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy. Covered Expenses:

- (1) for a Participating Dentist, do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the fee allowed by the Dentist's contract with the dental network;
whichever is less; or
- (2) for a Non-Participating Dentist's charges, do not exceed[:
 - (a)] for Type 1, 2 or 3 procedures, this Policy's Usual and Customary allowances[; and
 - (b) for all other covered procedures:
 - i) the Dentist's normal charge for a procedure; or
 - ii) the scheduled fee contained in this Policy;
whichever is less].

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by this Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of this Policy.

e. PPO Plan with Schedule for Out-of-Network:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy. Covered Expenses:

- (1) for a Participating Dentist, do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the fee allowed by the Dentist's contract with the dental network;
whichever is less; or
- (2) for a Non-Participating Dentist's charges, do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the scheduled fee contained in this Policy;
whichever is less.

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by this Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of this Policy.

f. Maximum Allowable Charge (MAC) PPO Plan:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy. Covered Expenses:

- (1) for a Participating Dentist, do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the fee allowed by the Dentist's contract with the dental network;
 whichever is less; or
- (2) for a Non-Participating Dentist's charges, do not exceed the Maximum Allowable Charge. The Maximum Allowable Charge is:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the lowest negotiated fee allowed by the dental network contracts with Participating Dentists; or, in the event there is no negotiated fee, the 50th percentile of this Policy's Usual and Customary allowances;
 whichever is less.

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by this Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of this Policy.

g. Scheduled Indemnity Plan, except U & C for Type 1, 2 or 3:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy. Covered Expenses do not exceed[:

- (1)] for Type 1, 2 or 3 procedures, this Policy's Usual and Customary allowances[; and
- (2) for all other covered procedures:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the scheduled fee contained in this Policy;
 whichever is less].

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by this Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of this Policy.

Covered Person, so that it can be expanded (to include members or partners, for instance) by group request.

Day or Date, so that it may be amended to accommodate group-specific needs.

Dependent and Dependent Dental Coverage, so that they can be omitted if not applicable.

Eligibility Waiting Period, so that it can be reworded to accommodate non-continuous and other non-standard waiting periods, or omitted when not applicable.

Employee, so that either Full-Time Employees or Full-Time Employees or Regular Part-Time Employees can be included. If needed to accommodate group-specific needs, the definition can be amended.

Expenses Incurred, so that the underlined number may range from 31 to 120, with 90 being the standard.

Family or Medical Leave definition is variable, so that it can be reworded to reflect any change in federal requirements; or, reference may be omitted for groups that are not subject to those federal requirements.

Full-Time Employee, so that eligibility can be based on working 15 to 40 hours per week (or hours over some longer period, such as a union hour bank or teaching schedule may require), and to amend the definition as needed to accommodate group-specific needs. In the event only full-time employees are covered under the policy, the definition of Full-Time Employee becomes the definition of Employee.

Group Policyholder, so that the second sentence may be omitted if not applicable.

Late Entrant, so that the underlined number of days can be longer than 31, if requested, and so that the definition can be omitted if not applicable.

Late Entrant Limitation Period, so that the definition can be omitted if not applicable.

Military Leave, so that it can be reworded to reflect any change in federal requirements; or, reference may be omitted for groups that are not subject to those federal requirements.

Non-Participating Dentist, so that this definition can be omitted when not applicable.

Open Enrollment Period, so that it can be omitted when not applicable, or so that it can be changed to accommodate retirees, associates, or other language as requested by the Group Policyholder; and so that the 31-day limitation can vary up to 60 days. Benefit Waiting Periods can be omitted when not applicable.

Orthodontic Treatment, so that this definition can be omitted when not applicable.

Participating Dentist, so that this definition can be omitted when not applicable.

Payroll Period, so that this definition can be omitted when not applicable.

Regular Part-Time Employee, so that the enumerated conditions may be altered or omitted by policyholder request; so that the "Group Policyholder" or "Participating Employer" language may be omitted or included as applicable; so that the underlined number of hours may be changed to accommodate a group's request; and so that the entire definition may be omitted when not applicable.

Retiree, so that the definition may be altered by policyholder request; so that the bracketed "full-time" be omitted when not applicable; so that the "Group Policyholder" or "Participating Employer" language may be omitted or included as applicable; and so that the entire definition may be omitted when not applicable.

Usual and Customary, so that the Group Insurance Service Office can be updated if necessary; and so that the entire definition can be omitted when not applicable.

3. **Eligibility and Effective Dates for Employee Dental Coverage. Forms GL11-6-ELE 07 and GL12-6-ELE 07**

Policy form *GL11-6-ELE 07* and certificate form *GL12-6-ELE 07* contain the Employee Eligibility and Effective Date provisions. We request that underlined references to Employees be variable to accommodate retiree, associate, member, or other language requested by the group. We request variable filing of the bracketed Eligibility language in order to accommodate group-specific requests. References to an Eligibility Waiting Period will be omitted when not required.

The bracketed Enrollment provision is to be used for groups that request an annual or open enrollment period; the provision will be omitted when not applicable.

We request variable filing of the Effective Date language, so that:

- (1) coverage can begin on the day, day following, first of month following, or any other specified day following the events listed;
- (2) reference to application or payroll deduction order can be omitted, when enrollment is automatic (as for noncontributory or replacement plans);
- (3) reference to Late Entrant can be omitted, when not required;
- (4) references to Section 125 Plans can be changed to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account;
- (5) increases and decreases in coverage can take effect on the day, the day following, the first of the month following, or other specified date following the events listed, or omitted when not applicable; and
- (6) the Active Work rule can be omitted when not applicable (or changed to a Nonconfinement rule for non-employees, such as retirees or association members).

We request variable filing of the bracketed Annual Enrollment Period language, so that it may be omitted when not applicable, or so that Open Enrollment can be substituted upon special request. The underlined references to Late Entrant Limitation Periods may be omitted when not applicable.

4. **Termination of Employee Dental Coverage. Forms GL11-7-TE 07 and GL12-7-TE 07**

Policy form *GL11-7-TE 07* and certificate form *GL12-7-TE 07* contain the Individual Termination provisions. We request that underlined references to Covered Employees or Employees be variable to accommodate retiree, associate, member, or other language requested by the Policyholder. We request variable filing of the bracketed Termination language, so that coverage can end on the day, last day of insurance month, or other specified date following the events listed.

Under the Continuation of Coverage provision, we request the following variability:

The bracketed Disability and Lay-off or Leave of Absence sections may be omitted when not applicable or at a group policyholder's request. The underlined durations can range from one to 60 Coverage/Policy/calendar months.

We request variable filing of the time periods under the Military Leave of Absence provision in order to accommodate any future changes in applicable federal and state laws.

Additional continuation provisions may be provided, as elected by the Policyholder. Such continuation provisions will be at least as favorable as state law requires.

The Reinstatement provision may be omitted when there is no Eligibility Waiting Period or Late Entrant requirement to waive, or reworded to accommodate group special requests to coincide with a group's administrative handling. We also request that the time periods under this provision be variable.

5. **Eligibility for Dependent Dental Coverage/Effective Dates for Dependent Dental Coverage. Forms GL11-8-ELD 09 AR and GL12-8-ELD 09 AR**

Policy form *GL11-8-ELD 09 AR* and certificate form *GL12-8-ELD 09 AR* contain the definitions, eligibility, effective date, and other provisions for Dependents. We request that underlined references to Covered Employees or Employees be variable to accommodate retiree, associate, member, or other language requested by the Policyholder. We request that the underlined ages be variable. The ages will never be lower than the dependent ages required by state law, but may be higher. Child dependent eligibility can be to a specified age or to a specified period of time, such as the end of the calendar year following the attainment of a specified age or the first day of the calendar year next following the attainment of a specified age. We also request that the underlined time periods under the Eligibility and Effective Dates provisions be variable so coverage can begin on the day, day following, first of the month following, or any other day following the events listed.

The bracketed language in the second and third paragraphs under the Eligibility provision is to be omitted when not applicable, as is the Annual Enrollment Period paragraph. The number of days is variable to the extent that it can be increased but not decreased. We request variable filing of the underlined Annual Enrollment Period language, so that Open Enrollment can be substituted upon special request.

The bracketed references to Benefit Waiting Periods and/or Late Entrant Limitation Periods may be omitted when not applicable.

We request variable filing of the Effective Date language, so that:

- (1) coverage can begin on the day, day following, first of month following, or any other specified day following the events listed;
- (2) reference to application or payroll deduction order can be omitted, when enrollment is automatic (as for noncontributory or replacement plans);
- (3) reference to Late Entrant can be omitted, when not required;
- (4) references to Section 125 Plans can be changed to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account; and
- (5) the language may be altered to accommodate special group requests.

We request variable filing of the underlined Section 125 language in the New Dependents section to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account. The underlined duration may range from 31 to 120 days.

The bracketed paragraph under the Exception provision may be omitted for plans with no Benefit Waiting Period(s) and/or Late Entrant Limitation Periods.

6. Termination of Dependent Dental Coverage. Forms GL11-9-TD 07 and GL12-9-TD 07

Policy form *GL11-9-TD 07* and certificate form *GL12-9-TD 07* contain the termination provisions for Dependents. We request that underlined references to Covered Employees or Employees be variable to accommodate retiree, associate, member, or other language requested by the Policyholder. We request variable filing of the underlined time periods so coverage can end on the day, day following, last day of the month following, or any other day following the events listed.

The Surviving Dependents provision is to be omitted for plans with no Dependent coverage. We request variable filing of the underlined duration in this paragraph, so that it may be increased if required by state law or Policyholder request.

The Reinstatement provision may be omitted when there is no Eligibility Waiting Period or Late Entrant requirement to waive, or reworded to accommodate group special requests to coincide with a group's administrative handling. We also request that the time periods under this provision be variable so that they may be increased if required by state law or Policyholder request. We request variable filing of the underlined Section 125 language to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account.

7. Premiums and Premium Rates. Form GL11-10-PR 09

For policy insert page *GL11-10-PR 09*, we request the underlined number of days permitted for the grace period to be filed as variable so the days may be increased to 45, 60, 90 or some other duration as requested by the Policyholder and agreed upon by underwriting. We request that the percentage of change in the number of employees to be filed as variable so it may be changed with a range of 15% to 50%, with 25% as the standard. The bracketed item 6 under the Premium Rate Change provision will be used only for Dual Option plans. The underlined "first" in reference to the anniversary (item 7) may be changed to reflect the appropriate applicable anniversary on which the rates will change. The notice of the rate increase will be at least 31 days or at least as favorable as required by state law. It may be increased to a maximum of six months upon request. We request the Premium Rate Schedule to be filed as variable since this section will include the rates applicable to the particular group.

8. Policy Termination. Form GL11-11-PT 08

For policy insert page *GL11-11-PT 08*, the notice of termination will be at least 31 days but may be increased upon request. The minimum number of employees may vary with 10 being the standard. Item (2) or (3) may be omitted if not applicable to the particular group. The underlined Section 125 Plan may be replaced by the actual name of the Plan or omitted, if not applicable. The underlined minimum participations may vary. The parenthetical reference in Item (2) may be omitted if dependent coverage is not provided. In Item (3), (b) may be omitted if dependent coverage is not provided. The bracketed paragraph at the end of the Termination By the Company section may be omitted. Under the Termination By Group Policyholder section, the underlined "on the date" is variable so that coverage can end on the day, the day following, the last day of the month following, or any other specified day.

9. **Dental Expense Benefits. Forms GL11-12-DB 07 and GL12-12-DB 07**

Policy form *GL11-12-DB 07* and certificate form *GL11-12-DB 07* describe the way Dental Expense Benefits are calculated for Types 1, 2, and 3 services (Preventive & Diagnostic, Basic, and Major Care). We request that the underlined references to Calendar Year be variable to accommodate plans that base benefits on the Policy Year, or some other period requested by the Group Policyholder.

We request that the bracketed sentences under the Deductible provision be filed as variable, so they may be omitted at the Policyholder's request.

We also request that the Benefit Waiting Periods and Late Entrant Limitation Periods provisions be filed as variable, so that they may be omitted at the Policyholder's request, if not applicable.

10. **Alternative Procedures. Form GL11-13-AP 07 and GL12-13-AP 07**

Policy form *GL11-13-AP 07* and certificate form *GL12-13-AP 07* explain the Alternative Procedures provision. No variability is requested for this provision.

11. **Dental Expense Benefits—Orthodontics for Children/Family Orthodontics. Forms GL11-14-DBO 07 and GL12-14-DBO 07**

Policy form *GL11-14-DBO 07* and certificate form *GL12-14-DBO 07* are Dental Expense Benefits insert pages for Type 4 services (Orthodontia). We request that the bracketed language in the form title be filed as omit-only variable in order to distinguish between plans that provide orthodontic coverage for children only, and those that provide orthodontic coverage for all covered family members. Similarly, we request that the underlined "Covered Person" language be filed as variable throughout, so that it may be substituted with "covered Dependent child" for child-only orthodontic coverage. We also request that the underlined references to the Schedule of Benefits be filed as variable.

The bracketed terms "begins" and "initial" will be the standard wording for orthodontic benefits, but we request variable filing of them in order to accommodate plans in which a Covered Person is not required to be banded while covered under our policy. For such plans, the word "begins" will be substituted with "receives," and the word "initial" will be deleted.

The bracketed Lifetime Maximum sentence and the Benefit Waiting Period and Late Entrant Limitation Period paragraphs will be omitted when not applicable.

12. **Limitations and Exclusions. Forms GL11-16-EX 09 and GL12-16-EX 09**

Policy form *GL11-16-EX 09* and certificate form *GL12-16-EX 09* list the Policy Limitations and Exclusions. The forms and phrases that are bracketed are material that may be omitted when not applicable, but not reworded. Also, the underlined term "Dependent child" is variable, so that it can be changed to "Covered Person," "Covered Employee," or other similar term, as needed or as requested by a group.

For a plan that covers Type 1, 2, and 3 services only, exclusion #5 will read, "Orthodontic (Type 4) services." When used with a plan that covers Type 1 and 2 services only, the exclusion will read, "Major (Type 3) services or Orthodontic (Type 4) services." The bracketed "which begins" will be used for plans that require the Covered Person to be banded while covered under our Policy (standard wording). "Received" will be used for plans that do not require banding while covered under our Policy. The bracketed "due to attainment of the maximum age, or for any other reason" may be omitted when not applicable.

13. **Coordination of Benefits. Forms GL11-17-COB 07 and GL12-17-COB 07**

Policy form *GL11-17-COB 07* and certificate form *GL12-17-COB 07* define terms used for Coordination of Benefits. No variability is requested for these forms.

14. **Dental Coverage Continuation. Forms GL11-20 07-COBRA and GL12-20 07-COBRA**

Policy form *GL11-20 07-COBRA* and certificate form *GL12-20 07-COBRA* provide the federal COBRA continuation requirements. We wish variability to the underlined portion of **TERMINATION** (2) in the event there is a Participating Employer under the policy.

15. **Continuity of Coverage. Forms GL11-CONT 09 and GL12-CONT 09**

Policy form *GL11-CONT 09* and certificate form *GL12-CONT 09* permit persons to continue coverage if enrolled in another employer's group dental plan within a specified number of days (31 days is the standard, but this may vary) before Dental Expense Benefits under this Policy take effect. We request that the following bracketed material be filed as variable:

- (1) Calendar Year, so that it can be changed to Policy or Plan Year upon request; and
- (2) the bracketed items in the Effect of Continuity of Coverage on Benefits paragraph, so that they may be omitted when the plan does not offer those benefits.

16. **Prior Plan Credit. Forms GL11-PIC 07 and GL12-PIC 07**

Policy form *GL11-PIC 07* and certificate form *GL12-PIC 07*, explain the Prior Plan Credit provision, used when our plan replaces an existing dental plan. We request variable filing of the underlined "on the day," so that coverage can begin on the day, day following, first of month following, or any other specified day. We request that the following bracketed material be filed as variable:

- (1) Group Policyholder, so that it can be changed to Participating Employer, as needed;
- (2) Calendar Year, so that it can be changed to Policy or Plan Year upon request; and
- (3) the bracketed items in the Effect on Prior Plan Credit paragraph, so that they may be omitted when the plan does not offer those benefits.

17. **List of Covered Dental Procedures. Forms GL11-DP.1 07, GL11-DP.2 07, GL11-DP.3 07, GL11-DP.4 07, GL11-DPSB.1 07, GL11-DPSB.2 07, GL11-DPSB.3 07, GL11-DPSB.4 07, GL12-DP.1 07, GL12-DP.2 07, GL12-DP.3 07, GL12-DP.4 07, GL12-DPSB.1 07, GL12-DPSB.2 07, GL12-DPSB.3 07, and GL12-DPSB.4 07**

These forms list Covered Dental Procedures. The *DP.1* version lists Type 1 (Diagnostic and Preventive) services, the *DP.2* version lists Type 2 (Basic) services, and so on. The *DPSB* versions of these forms are for use with Scheduled Indemnity plans. These forms are variable so that upon request, certain procedures can be moved to a different type, or so that new procedures can be added and outdated procedures can be deleted. For instance, a Policyholder may choose to have Sealants covered as either type 1 or type 2, or Periodontics to be covered as either type 2 or type 3. Procedures relating to treatment of the temporomandibular joint (TMJ) may be added where required by law, or by Group Policyholder request.